JAMES E. RISCH – Governor RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

July 21, 2006

Greg Bolen, Administrator Life Care Center of Sandpoint 1125 North Division Street Sandpoint, ID 83864

Provider #: 135127

Dear Mr. Bolen:

On **June 22, 2006**, a Complaint Investigation was conducted at Life Care Center of Sandpoint. Marcia Key, R.N. and Lisa Kaiser, R.N. conducted the complaint investigation. 44 survey hours were required to complete this and two other investigations at the facility. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001340

ALLEGATION #1:

The complainant stated residents are not receiving baths due to insufficient staff. Staff are documenting they are giving baths when they are not.

FINDINGS:

The surveyors could not validate that staff were documenting they were giving residents their baths. However, the facility was cited at F166 for failure to resolve resident grievances in regards to receiving their scheduled baths and at F312 for not ensuring all residents received their scheduled baths.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Greg Bolen, Administrator July 21, 2006 Page 2 of 3

ALLEGATION #2:

The complainant stated an identified resident had a pressure ulcer on her foot. The complainant alleged the facility was documenting the pressure ulcer as an abrasion. The facility was treating the wound with a "no sting" barrier which is not an appropriate treatment for the wound.

FINDINGS:

The identified resident's record was reviewed. The wound on the resident's foot was documented as a shallow Stage 2 injury. The "no sting" barrier was used on the resident prior to applying the hydrocolloid dressing. After the wound closed, the facility continued to apply the "no sting" barrier as a skin protectant. "No sting" barrier can be used over denuded or partial thickness skin loss to assist in protecting the surrounding skin and to assist with wound dressing adherence. The properties of the barrier film provide a non-painful protective layer over the area.

The facility was cited at F314, however, for failure to prevent a Stage 2 pressure ulcer on the resident's toe.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated identified residents had sustained falls due to insufficient staffing. One identified resident had two or three falls in one day.

FINDINGS:

The identified residents' Incident and Accident investigation reports were reviewed.

The facility was cited at F225 for failure to thoroughly investigate incident/accidents; at F324 for failure at provide adequate supervision and assistive devices to prevent accidents; at F353 for failure to have sufficient nursing staff to provide nursing and related services to maintain residents at their highest level of functioning; and at F490 for failure to administer the facility in a manner that enables it to use its resources effectively and efficiently toward the betterment of each resident.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the

Greg Bolen, Administrator July 21, 2006 Page 3 of 3

Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

MARCIA KEY, R.N. Health Facility Surveyor Long Term Care

MK/dmj

JAMES E. RISCH – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

July 21, 2006

Greg Bolen, Administrator Life Care Center of Sandpoint 1125 North Division Street Sandpoint, ID 83864

Provider #: 135127

Dear Mr. Bolen:

On **June 22, 2006**, a Complaint Investigation was conducted at Life Care Center of Sandpoint. Marcia Key, R.N. and Lisa Kaiser, R.N. conducted the complaint investigation. A total of 44 hours were required to complete this and two other investigations at this facility. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001487

ALLEGATION #1:

The complainant stated an identified resident did not get a bath from May 3 through May 23, 2006.

FINDINGS:

The identified resident's bath record was reviewed for the month of May 2006. The only documented shower was on May 2, 2006. There was no other documentation in the resident's record to indicate she had been bathed or showered any time between May 2, 2006 and May 23, 2006 when she was transported to the emergency room for a Polymicrobial toe infection.

The facility was cited at F312 for failure to provide residents with adequate bathing.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Greg Bolen, Administrator July 21, 2006 Page 2 of 2

ALLEGATION #2:

The complainant stated an identified resident had a wound on her toe which became infected and draining. The wound required hospitalization and was initially discovered by a private caregiver visiting the resident.

FINDINGS:

The identified resident's record was reviewed. The facility was cited at F309 at the level of immediate jeopardy for failure to identify, assess and treat the resident's infected toe in a timely manner.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

MARCIA KEY, R.N. Health Facility Surveyor

Marcina Key

Long Term Care

MK/dmj

JAMES E. RISCH -- Governor RICHARD M. ARMSTRONG -- Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

July 21, 2006

Greg Bolen, Administrator Life Care Center of Sandpoint 1125 North Division Street Sandpoint, ID 83864

Provider #: 135127

Dear Mr. Bolen:

On **June 22, 2006**, a Complaint Investigation was conducted at Life Care Center of Sandpoint. Marcia Key, R.N. and Lisa Kaiser, R.N. conducted the complaint investigation. A total of 44 survey hours were required to complete this and two other investigations at this facility. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001540

ALLEGATION #1:

The complainant stated residents do not receive baths according to their care planned needs. Some residents only receive one or two showers per month. The lack of scheduled showers was especially prevalent in April and May, 2006.

FINDINGS:

Review of bathing records and resident grievances and staff and resident interviews revealed that residents did not receive their baths according to scheduled care planned needs. The facility was cited at F166 for failure to address and resolve resident grievances in regards to residents not receiving their scheduled baths and F312 for failure to ensure residents received the necessary services to maintain personal hygiene in regards to bathing.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Greg Bolen, Administrator July 21, 2006 Page 2 of 2

ALLEGATION #2:

The complainant stated there is insufficient staffing in the facility to provide for residents' needs.

FINDINGS:

Interviews with residents and staff, review of resident records and review of the facility's incident/accident reports revealed the facility did not have sufficient staff to meet resident needs. The facility was cited at F324 for failure to provide adequate supervision for residents to prevent accidents; at F353 for failure to have sufficient nursing staff to provide nursing and related services to maintain residents at their highest level of functioning; and at F490 for failure to administer the facility in a manner that enables it to use its resources effectively and efficiently towards the betterment of each resident.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

MARCIA KEY, R.N. Health Facility Surveyor

Marcia Ken

Long Term Care

MK/dmj

JAMES E. RISCH – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8897

July 7, 2006

Greg A. Bolen, Administrator Life Care Center of Sandpoint 1125 North Division Street Sandpoint, ID 83864

Provider #: 135127

Dear Mr. Bolen:

On June 22, 2006, a Complaint Investigation survey was conducted at Life Care Center of Sandpoint by the Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be isolated and to constitute immediate jeopardy to resident health and safety. You were informed of the immediate jeopardy situation in writing on June 21, 2006.

On **June 22, 2006**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the resident had been removed. However, the deficiencies as identified on the revised CMS Form 2567L remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the CMS Form 2567L, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in

Greg A. Bolen, Administrator July 7, 2006 Page 2 of 5

compliance. After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 20, 2006**. Failure to submit an acceptable PoC by **July 20, 2006**, may result in the imposition of additional civil monetary penalties by **August 9, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42*, *Code of Federal Regulations*.

Based on the immediate jeopardy F309 -- S/S: J -- 483.25 -- Quality Of Care cited during this survey, we are recommending to the CMS Regional Office that the following remedies be imposed:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

A 'per instance' civil money penalty of \$5000.00. (THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED AT §7510) (§488.430)

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Greg A. Bolen, Administrator July 7, 2006 Page 3 of 5

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 22, 2006**, if substantial compliance is not achieved by that time.

Your facility's noncompliance with the following:

has been determined to constitute substandard quality of care as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) require that the attending physician of each resident who was found to have received substandard quality of care as well as the State board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Resident #1 as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/ Rainbow/Documents/medical/2001_10.pdf http://www.healthandwelfare.idaho.gov/ Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **July 20, 2006**. If your request for informal dispute resolution is received after **July 20, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

STATE ACTIONS effective with the date of this letter (July 7, 2006):

Due to the serious nature of the deficiencies at C784, the Department is placing the facility on a

Provisional License. Enclosed is Skilled Nursing Facility License #80. This license is effective through **January 7, 2007**. The conditions of the Provisional License are as follows:

- 1. Correction of all the deficiencies, with special attention to correction of C784.
- 2. The facility must obtain weekly consultation from a qualified RN, licensed in Idaho, who is not an employee of the facility. A corporate RN consultant can meet this requirement. The consultant must provide weekly reports to this office, indicating each deficient area has been reviewed, and corrective actions taken, and the current status of each deficient area.
- 3. A ban on all admission is being placed on the facility, effective the date of this letter, in accordance with *Title 3, Chapter 12, Rules Governing Long Term Provider Remedies in Idaho*, Section 16.03.12.004.08, which allows additional remedies when non-compliance with program requirements is found.

<u>IDAPA Section 16.03.12.004.08.</u>, states:

08. Ban on Admissions. Such bans to the facility or to any part thereof shall remain in effect until the State Survey Agency determines that the facility has achieved substantial compliance with all program requirements or until a substitute remedy is imposed.

Failure to comply with the conditions of the Provisional License may result in revocation of the facility's license. <u>IDAPA 16.03.02.003.05.a.</u> states:

- a. Additional causes for denial of a license may include the following:
 - I. The applicant has violated any conditions of a Provisional License.

Please be advised that you are entitled to request an administrative review regarding the issuance of the Provisional License. In order to be entitled to an administrative review, you must submit a written request to the State Survey Agency within fourteen (14) days from the date upon which you received this letter. The request must state the grounds for the facility's contention that Provisional License was inappropriate. Because a Provisional License may be issued whenever a facility is in substantial compliance with but does not meet every requirement or rule, during the review, you would be expected to demonstrate that none of the findings of deficiency were justified.

In any administrative review, you should be prepared to demonstrate that the Department's findings were in error.

Greg A. Bolen, Administrator July 7, 2006 Page 5 of 5

You should also include any documentation or additional evidence that you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to, Randy May, Deputy Administrator, Division of Medicaid, 3232 Elder Street, PO Box 83720, Boise ID 83720-0036, Phone #: (208) 334-5747, Fax #: (208) 364-1811.

The rules and regulations governing the conduct of an administrative review are set forth at <u>IDAPA 16.05.03.300</u>. If you fail to timely request an administrative review, the Department's decision to impose remedies as set forth herein becomes final. Please note that issues, which are not raised at an administrative review, may not later be raised at higher level hearings (<u>IDAPA 16.05.03.301</u>).

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

LORETTA TODD, R.N.

Supervisor

Long Term Care

LT/dmj

Enclosures

PRINTED: 07/06/2006 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIF	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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F 000	Complaint investigation The surveyors convere: Marcia Key, RN, T Lisa Kaiser, RN Survey Definitions MDS = Minimum I RAI = Resident As RAP = Resident As DON = Director of LN = Licensed Nu RN = Registered I CNA = Certified N ADL = Activities of MAR = Medicatio 483.10(f)(2) GRIE A resident has the facility to resolve (shave, including the of other residents. This REQUIREMED Based on staff intromplaints from the facility failed to retimely manner. Grief the surveyor	ciencies were cited during a cation at the facility. Iducting the investigation survey Team Coordinator Cata Set assessment instrument issessment Instrument issessment Protocol Nursing rise Nurse Urse Aide If Daily Living In Administration Record VANCES Oright to prompt efforts by the grievances the resident may one with respect to the behavior ENT is not met as evidenced Perview, record review, and the public, it was determined the solve resident grievances in a rievances were reviewed for the		166	This plan of correction is subrequired under Federal and Statues applicable to long term providers. This plan of correct does not constitute an admiss liability on the part of the fact such liability is hereby specified denied. The submission of this does not constitute agreement facility that the surveyors' find and/or conclusions are accurate findings constitute a deficit that the scope and severity reany of the deficiencies cited accorrectly applied. F-166 SPECIFIC RESIDENTS Resident # 2 has been spoker concerns and has verbalized satisfaction with facility correction and has voiced no furticencerns. Resident # 4's concern with seen addressed and no further concerns have been voice. Statistically was educated and no further concerns have been voice. Statistically was educated and no further concerns have been voice. Statistically was educated and no further concerns have been voice. Statistically was educated and no further concerns have been voice. Statistically was educated and no further concerns have been voice. Statistically was educated and no further concerns have been voice. Statistically was educated and no further concerns have been voice.	State m care ction cion of cility, and cally s plan t by the cate, that ciency or carding are RE FACILITY a to about ective her caff	CEIVE 19 2006 STANDARDS
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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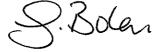
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKDX11

Facility ID: MDS001420

If continuation sheet Page 2 of 52



PRINTED: 07/06/2006 FORM APPROVED OMB NO. 0938-0391

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	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTE PROPERTY OF LETTE	RE CENTER OF SANDPOINT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 *Facility Investigation & Response - blank *Action Taken to Resolve/Respond to Concern - blank The grievance form was signed by the facility's ED and dated 5/30/06. 3. Resident #5 grievance report, dated 5/28/06 at 11:20 am, documented the following information: *Concern or Comment - Lost - missing pair hand chrocheted [sic] slippers mauve & white. *Facility Investigation & Response - blank *Action Taken to Resolve/Respond to Concern - blank. The grievance form was signed by the facility's ED and dated 5/30/06. 4. Resident #6's grievance report, dated 5/19/06 at 1:30 pm documented the following information: *Concern or Comment - "[Resident #6] had a headache & was seeking Tylenol from [name of LN]. She ignored his needs & [resident #6] stated 'I didn't know you had such a dark side' To which she replied 'Your true colors are showing' Resident stated her attitude was poor & she gave him lip." *Facility Investigation & Response - blank *Action Taken to Resolve/Respond to Concern -	RE CENTER OF SANDPOINT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 *Facility Investigation & Response - blank *Action Taken to Resolve/Respond to Concern - blank The grievance form was signed by the facility's ED and dated 5/30/06. 3. Resident #5 grievance report, dated 5/28/06 at 11:20 am, documented the following information: *Concern or Comment - Lost - missing pair hand chrocheted [sic] slippers mauve & white. *Facility Investigation & Response - blank *Action Taken to Resolve/Respond to Concern - blank. The grievance form was signed by the facility's ED and dated 5/30/06. 4. 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AD 07-17-06

PRINTED: 07/06/2006 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		135127	B. WIN	з		1	2/2006
	ROVIDER OR SUPPLIER			11	EET ADDRESS, CITY, STATE, ZIP CODE 25 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENS	TATEMENT OF DEFICIENCIES CY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 166	The grievance for ED and dated 5/2 5. Resident #2's gat 1:15 pm, docu *Concern or Comfor S.S. [Social S & Both of them sincountered [sic] R/T [related to] medication & who [as needed] men Transfer [with] tu wanted to Transf Administration] h Family needs to [catheter] D/C [dis/s [signs and syinfection] for 4 Diresponded now he *Facility Investigates and the signated to investigate and the signate and the signat	rm was signed by the facility's 29/06. grievance report, dated 5/24/06 mented the following: ment - " Wife & Daughter asked ervices] went down to RM [room] tated some concerns they have since admit. 1) Bowel concern hedication given 2) pain en & why & dose 3) What PRN it [sic] & when that was given 4) be and how staff is to do that 5) for to VA [Veterans' osp. [hospital] 6) How come provide oral care. 7) Cath. scontinued] and poss. [possible] mptoms] of UTI [urinary tract asys before they felt staff has full blown UTI." ation & Response - "Individual restigate concern: [name of consultant]" No other information in this portion of the form. Resolve/Respond to Concern - le completed 5/25/06 - fax to MD tidepressant & consul[tation] t. Ativan now prn. RD [Registered at done 5/24/06. O2 [oxygen] sats to be done Q [every] shift & Documentation in this portion of at that the information had been be resident's wife on 5/25/06 and ned party's response to action	F 1	66	(PI) meeting so that identifie can be addressed. MONITORS Social Service Director (SSI monitor through the grievand tracking log. ED will monitor through rev signing of each grievance. DATE OF COMPLIANCE:	D) will ce iew and	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		NG	(X3) DATE SUI COMPLET	ED
		135127	B. WII	۷G _		06/22	1
	ROVIDER OR SUPPLIER	DPOINT		'	TREET ADDRESS, CITY, STATE, ZIP CODE 1125 N DIVISION ST SANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIES YMUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΊX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 166	Continued From pa	age 4	F	166	6		
	The grievance forn ED and dated 5/26	n was signed by the facility's 1/06.					
	form regarding the regarding oral care resident's wish to the with the catheter a infection.	umentation on the grievance facility's investigation the bowel concern, the transfer to the VA, or the issue and the subsequent urinary tract					
	6. Resident #3's grat 12:15 pm, docuinformation:	rievance report, dated 4/18/06 mented the following					
	brought to room, FPT] entered room, her condition and PT] (of [name of b physician] had toke therapists in town back problem: [name of 3rd PT], and on provided therapy session with the poor states [name of plates the problem of provided the provided th	ment - "After lunch tray was P.T. [physical therapy]/[name of Resident states she described therapy given by [name of 2nd business]). States [name of diresident there are only 3 he'd trustwith her particular me of second PT], [last name be other. [Name of 2nd PT] and following/because of the ras admitted to [local area florphine x4 days. Resident the consult [with] therapist/[name of edid. States [name of 2nd PT] on 9/18/06 she's too fragile and in her lower back, resident therapy until surgery is done, that e therapy could be done but not at [name of physician] said, when ased from her 4-day stay in ad Morphine, that she should be end a lot of time on her back,					

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ND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G		OMPLETED C	
135127	B. WING		06/22/2006		
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT	11	REET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
that discharge orders were for bedrest, chair sitting, and bedside commode prior to the decision to admit to [name of facility]. Resident asked P.T. to call [name of 2nd PT] and consult with her and resident was told 'I'm not going to do that. I wouldn't talk to a woman. I have a Master's Degree and I've worked with geriatrics for six years."' *Facility Investigation & Response - blank *Action Taken to Resolve/Respond to Concern - blank The grievance report was signed by the facility's ED and dated 4/19/06. On the morning of 6/21/06, the facility's ED was interviewed regarding the resolution of grievances. The ED acknowledged that he had not doubts that the above-mentioned grievances were resolved. He was not able to produce documentation of the resolutions. In regards to resident #7's grievance alleging a CNA was rude, he stated, "She doesn't work here anymore" In reference to resident #2's allegation of staff touching food during meal set-up and that they didn't wash their hands in between cares, he stated, "I made an observation in the dining room and did not see this [staff touching food, licking their fingers] occurring" In regards to resident #3's grievance about an encounter with a specific PT, he stated, "we checked into thattha was a personality conflict" The facility failed to ensure that resident grievances were resolved. The facility's Executive	a t				

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 06/22/2006	
		135127	B, WIN	IG			
	ROVIDER OR SUPPLIER	DPOINT		11	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 166	Continued From pa	age 6 ch grievance as completed with ntation present to indicate illity's investigation and the	F	166	DEFICIENCY)		

S. Bolan

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Event ID: IKDX11

Facility ID: MDS001420

PRINTED: 07/06/2006 FORM APPROVED OMB NO. 0938-0391

STREET ADDRESS, CITY, STATE, ZIP CODE 1/25 NOWISION ST SANDPOINT B 3864		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION 3	(X3) DATE SU COMPLE	TED
LIFE CARE CENTER OF SANDPOINT 1128 N DIVISION ST SANDPOINT, ID 83864 PREVIX			135127	B. WIN	1G			
FREETY TAG FREGULATORY OR LSC IDENTIFYING INFORMATION) F 225 SS=E TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate uniftness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 8 working days of the incident, and if the alleged violation is verified TF 225 SPECIFIC RESIDENTS Resident #15 and #9 have discharged. Resident #15 and #9 have disch			DPOINT		11	125 N DIVISION ST		
The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
This REQUIREMENT is not met as evidenced		TREATMENT OF The facility must in been found guilty or mistreating resider had a finding enter registry concerning of residents or mis and report any know court of law against indicate unfitness other facility staff to or licensing author. The facility must expressed involving mistreatr including injuries or misappropriation or immediately to the to other officials in through established State survey and or the facility must have a survey an	ot employ individuals who have of abusing, neglecting, or hats by a court of law; or have red into the State nurse aide g abuse, neglect, mistreatment appropriation of their property; owledge it has of actions by a st an employee, which would for service as a nurse aide or the State nurse aide registry rities. Insure that all alleged violations ment, neglect, or abuse, of unknown source and of resident property are reported administrator of the facility and accordance with State law and procedures (including to the certification agency). Insure evidence that all alleged oughly investigated, and must tential abuse while the progress. Investigations must be reported or or his designated of to other officials in accordance studing to the State survey and the progress of the state survey and only within 5 working days of the state action must be taken.	F;		Resident # 15 and # 9 have discharged. Resident #'s 1, 7, 8, 10, 11, 1 16, 17, 18 and 19 will have a of unknown origin thoroughl investigated to determine cau preventive measures implemented as the potential all residents. Residents who sfall or have injuries of unknown have a thorough investigation event to determine cause, rule abuse/neglect and preventive implemented as appropriate. SYSTEMIC CHANGES A new revised accident/incid has been implemented to ens	Il injuries y use and ented as Il to affect sustain a wn origin of the e out measures ent form ure a	

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	F OF DEFICIENCIES - DEFICIENCIES -	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
PART FULL			A. BUILDI	NG		
		135127	B. WING		1	2/2006
	PROVIDER OR SUPPLIER	DPOINT	s ⁻	TREET ADDRESS, CITY, STATE, ZIP CO 1125 N DIVISION ST SANDPOINT, ID 83864	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 225	by: Based on review of (I/A) reports, staff from the public, it not ensure that un of unknown origin rule out abuse or months of I/A reports of I/A reports for the injury. There was facility ruled out stage (Resident #1) sus origin to her right immediate investion of the injury. She developed a Polyr requiring hospitality topical, and intravareports for resident recorded no Execution of the injury. She developed a Polyr requiring hospitality topical, and intravareports for resident recorded no Execution of the injury. She developed a Polyr requiring hospitality topical, and intravareports for resident recorded no Execution of the injury. She includes the include: 1) Resident #15's following: 5/13/06 at 8:30 properties the includes includes at 8:30 propensed. Resident witnessed on floor - fallResident witnessed on floor - fallResident witnessed on floor - fallResident resident witnessed on floor - fallResident resident witnessed on floor - fallResident resident resident witnessed on floor - fallResident resident	of the facility's Incident/Accident interview, and three complaints was determined the facility did witnessed falls/ and or injuries were thoroughly investigated to neglect. One I/A report of the 3 orts reviewed, (Resident #15's) and an unwitnessed fall when she sustained a hip as no documented evidence the raff error, abuse or neglect. Itained an injury of unknown great toe. There was no gation as to the probable cause was harmed when she microbial infection in the toe zation and treatment with oral, enous antibiotics. Also, the I/A ants (#1 and #s 7 through 19) utive Director or designee by the reports were reviewed to exist and date the reports, on of the investigation, within 5 or an I/A occurs. Findings I/A report documented the m,"Describe exactly what the ent walked to restroom by a affected: R[ight] hipWas defected: R[ight] hipWas defected: R[ight] hipWas defected: Reconstitution before citivity at the time of the incident:	F 22	ED and Director of Nursi have been in-serviced on accident/incident manage follow-up on 7-3-06. Staff was in-serviced on the new accident form an injury prevention on 7-18 Accident/incidents are br Daily Stand-Up meeting and completion by the IE ED & DON review and saccident/incident form for completion of the form a 5 days of the event. MONITORS ED and DON will monit review and signing of the accident/incident reports DATE OF COMPLIANCE	completion of ad on fall and and 7-19. cought to the for review or. sign each ollowing and within or through	

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	IULTIP ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 06/22/2006	
		135127	B. Wil	VG			
	ROVIDER OR SUPPLIE			11	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	resident's menta Alert & oriented of pain after the scale]Was first than left R leg tu painWas perso YesWas anoth involved? No" The section, FO documented the "Describe the call light found re how long was th he/she was foun mobility status? if any, environme contributed to th sides of commo measures were commode - non resident involved involved? NoV by staff, and by The section of ti INTERVIEW FO "Title of witnes charting I saw h into her room & with her right leg leg I lifted her le outward and sh told her that I'm be back and I w	I condition after the incident? .Describe the resident's intensity incident: 7-10 [on pain aid administered? R leg shorter rned outward - [increased] on involved taken to a hospital? er resident or associate UND ON THE FLOOR/FALL,		225			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		135127	B. WI	IG		06/22	2/2006
	ROVIDER OR SUPPLIER			112	ET ADDRESS, CITY, STATE, ZIP CODE 25 N DIVISION ST NDPOINT, ID 83864		
(X4) 1D PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	if further investiga available regardin report titled, Incid Recommendation documented the full report titled, Incid Recommendation documented the full report titled, Incident Followin [First box] No abutage of the boxes were for Executive Director, Medical Director, The section SUM FACTS, and an appropriate proviously documented evident following full report of the boxes were for Executive Director, ACTION intervention in place of the section, ACTION intervention in place of the section following following full report of the section following full report of the section full report	ative documentation was ag this incident. She provided a ent Follow-Up & Form, dated 5/16/06, which	F	225			

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 225	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIF	PLE CONSTRUCTION	(X3) DATE SU COMPLET	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT C(4) ID PREFTX TAG TAG TAG TAG TAG TAG TAG TA	AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	<u> </u>	i	
LIFE CARE CENTER OF SANDPOINT X3 SUMMARY STATEMENT OF DEFICIENCIES (CACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE (PACH DEFICIENCY) F 225 Continued From page 11 assessed the resident for injuries. The resident was harmed when she sustained a right hip fracture. The Executive Director was interviewed on 6/21/06 at approximately 6:30 pm regarding his role during the investigation process. He stated the A & I Committee consisted of the DON, Nurse Manager, and staff from Social Services and Activities. He stated the committee reviews incidents and accidents on a routen basis. The facility failed to thoroughly investigate this I/A when they did not interview the alert resident to determine the cause of the fall, which resulted in a hip fracture, to rule out the possibility of staff error, a second resident involvement, or abuse/neglect. The facility also did not interview other staff who worked that shift to rule out the same issues. Based on the available documentation, this was an I/A which was of unknown origin, was not ruled out as being staff error, abuse or neglect. 2) Resident #1 had an occurrence on 5/23/06. The I/A report documented: "Describe exactly what happened: When removing socks, toe nail was pulled off Riightly great toe nail revealing large open area [with] vellow slough covering wound &			135127	B. WI	√IG		1	1
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY UILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OT CORRECTION (CANCES REFERENCED TO THE APPROPRIATE DATE)			DPOINT	1125 N DIVISION ST		125 N DIVISION ST		,
assessed the resident for injuries. The resident was harmed when she sustained a right hip fracture. The Executive Director was interviewed on 6/21/06 at approximately 6:30 pm regarding his role during the investigation process. He stated the A & I Committee consisted of the DON, Nurse Manager, and staff from Social Services and Activities. He stated the committee reviews incidents and accidents on a routine basis. The facility failed to thoroughly investigate this I/A when they did not interview the alert resident to determine the cause of the fall, which resulted in a hip fracture, to rule out the possibility of staff error, a second resident involvement, or abuse/neglect. The facility also did not interview other staff who worked that shift to rule out the same issues. Based on the available documentation, this was an I/A which was of unknown origin, was not ruled out as being staff error, abuse or neglect. 2) Resident #1 had an occurrence on 5/23/06. The I/A report documented: "Describe exactly what happened: When removing socks, toe nail was pulled off R[ight] great toe nail revealing large open area lightly lellow slough covering wound &	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEEDED BY FULL	PREF	IX.	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF	ULD BE	(X5) COMPLETION DATE
necrotic tissue at tip of toe. Also a 0.5 cm [centimeter] lesion to medial 2nd toe [with] yellow bedResident's mental condition before incident: Alert/confused" Under the section, SKIN RELATED INJURY, the following was recorded: "Categorize the skin related injury. Infected	F 225	assessed the residuals harmed when fracture. The Executive Dire 6/21/06 at approximate of a look of the A & I Committed Manager, and state incidents and accimate of the facility failed for the f	dent for injuries. The resident she sustained a right hip ector was interviewed on mately 6:30 pm regarding his estigation process. He stated see consisted of the DON, Nurse ff from Social Services and ed the committee reviews dents on a routine basis. to thoroughly investigate this I/A interview the alert resident to use of the fall, which resulted in rule out the possibility of staff esident involvement, or the facility also did not interview orked that shift to rule out the illable documentation, this was of unknown origin, was not ruled error, abuse or neglect. and an occurrence on 5/23/06. Commented: "Describe exactly When removing socks, toe nail ght] great toe nail revealing large yellow slough covering wound & tip of toe. Also a 0.5 cm on to medial 2nd toe [with] yellow mental condition before incident: Under the section, SKIN RY, the following was recorded:		225			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	PLE CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING			С
		135127	B. WING		06/2	2/2006
	ROVIDER OR SUPPLIER		11	EET ADDRESS, CITY, STATE, ZIP C 125 N DIVISION ST ANDPOINT, ID 83864	:ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	transfersDid the Unknown, possibly transfer" The followere left blank: "V What did the investion of the if the Incident Follower Form had been contained by the surrougheted. There for this resident. The facility failed to incident to determing injury. The injured private caregiver attention of the standility investigate an infected wound told by the private became aware of She was harmed Polymicrobial inference hospitalization and intravenous at The Executive Diriging the report to determine if the inperson must sign completion of the days after an I/A of "Location of incident to determine if the inperson must sign completion of the days after an I/A of "Location of incident to determine if the inperson must sign completion of the days after an I/A of "Location of incident to determine if the inperson must sign completion of the days after an I/A of "Location of incident to determine if the inperson must sign completion of the days after an I/A of "Location of incident to determine if the inperson must sign completion of the days after an I/A of "Location of incident to determine if the inperson must sign completion of the days after an I/A of "Location of incident to determine if the inperson must sign completion of the days after an I/A of "Location of incident to determine in the inperson must sign completion of the days after an I/A of "Location of incident to determine in the inperson must sign completion of the days after an I/A of "Location of incident to determine in the inperson must sign completion of the days after an I/A of "Location of incident to determine in the inperson must sign completion of the days after an I/A of "Location of incident to determine in the inperson must sign completion of the days after an I/A of "Location of incident to determine in the inperson must sign completion of the days after an I/A of "Location of incident to determine in the inperson must sign completion of the days after an I/A of "Location of incident to determine in the inperson must sign completion of th	injury involve equipment? y stubbed on bed or w/c during lowing questions on the form vas there an investigation? stigation reveal?" afternoon, the DON was asked ow-Up & Recommendation ompleted. She indicated she veyors all the forms that she had was no follow-up information to thoroughly investigate this line the probable cause of the toe was first observed by a who brought the wound to the aff. There was no evidence the d why the toe had progressed to d and why the staff had to be caregiver before the facility the seriousness of the wound, when she developed a ction in the toe requiring d treatment with oral, topical, intibiotics. There was reviewed to exercise the reports, verifying investigation, within 5 working	F 225			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	ULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
and Plan O	F CORRECTION	IDENTIFICATION NUMBER:	1	LDING	**************************************		
		135127	B. Wil	/G		06/22	2/2006
	ROVIDER OR SUPPLIER	DPOINT		11	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
		ATEMENT OF DEFICIENCIES	ID	3,	PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	/ MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE
F 225	Continued From page	age 13	F	225			
	Found on floor on chair. Falls alarm in affected: none not ON THE FLOOR/If Was falls alarm so circumstances: Re	#9's name] was in need of help. L[eft] side in front of wheel not attached. Body part edUnder the Section, FOUND FALL: Was falls alarm on? Yes. bunding? Yes. Describe the esident leaned forward. Was the ht? No. Was the floor wet?					
	following question environmental bar the incident? Was resident involved?	this section, which included the s, was blank: "What, if any, riers potentially contributed to the call light on? Was another? Was an associate involved? sident last seen by staff, and by					
	Form, dated 4/17/ have reviewed all made the followin [First box] No abu [second box] Una neglect or misapp neglect of misapp of the boxes were SUMMARY OF IN documented: On resident @ [at] ap am,] resident need front of w/c [wheed to resident's cloth injury"	ow-Up & Recommendation 106, documented the following: "I investigative data and have g determination: (check one): use, neglect, misappropriation, ble to substantiate abuse, propriation, [third box] Abuse, propriation substantiated." None e checked. The section, NVESTIGATIVE FACTS, 4/15/06 alerted by another prox [approximately] 1015 [10:15 used help found resident sitting in the chair] Falls alarm [not]attached les, slipped out [no] apparent					
	occurrence to rul	ot thoroughly investigate this e out the possibility of staff error, t's involvement in the incident, or					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		135127	B. WII			06/22	2/2006
	ROVIDER OR SUPPLIER	POINT		11	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	investigate to clarify relating to alarms. staff on duty nor bruises was unknown staff on the right of centimeters. The computer of the report form, dated "Resident claims transferring to & from was not signed Director. There were similar 10 through 19, who or bruising/abrasion were not thorough! Executive Director the reports to verify	facility did not thoroughly the conflicting information. There were no interviews by atements by the resident or the no reported the incident. The DON, and Medical Director ne investigation report as being to the distribution of the staff of the resident in the shower noted on the resident's legs. If the bruise on the resident's lateral lower leg measured 2x3 incumstance surrounding the	F:	225			

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3D 04-17-06

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STATEMENT OF DEFICIEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIF	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
AND PLAN OF CORRECTI	JN	SELECTION NOME IN	A. BUI	LDING			,
		135127	B. WIN	1G		i -	2/2006
NAME OF PROVIDER OR		DPOINT		STREET ADDRESS, CITY, STATE, ZIP CO 1125 N DIVISION ST SANDPOINT, ID 83864			
POETY (EACH	DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
provide the or maintal mental, a accordant and plan. This REC by: Based or complaint facility farmonitor as she deverguiring topical, a practice immedia (#1). a. Reside 3/29/06 to bleed at any document any document and a plan. The complete of the compl	dent must be necession the high of psychologome. QUIREME a staff interpretation of care. QUIREME a resident be idea resident be idea of the interpretation of after the removed a wound as visual and off due intation or describe with "yello tissue @ so document of the production of the idea of the interpretation of the idea of t	of care It receive and the facility must sary care and services to attain hest practicable physical, osocial well-being, in he comprehensive assessment INT is not met as evidenced erviews, record review, and a e public it was determined the equately assess, treat and 's injury causing harm when holymicrobial infection in the toe exation and treatment with oral, enous antibiotics. This deficient in serious harm, constituting dy to 1 of 1 sample residents raped her right great toe on he facility, causing the toe to il. The facility could not provide in indicating the toe was he initial incident nor that it was he initial incident nor that it was he do not 5/23/06, a private he to the resident's socks and he to the right great toe. The hized after the resident's toenail he to the removal of the sock. The incident report, dated he wound as a "large open he slough covering wound [and] [at] tip of toe." The incident hented a 0.5 centimeter lesion to he to with a yellow wound base.	F:	309	F-309 SPECIFIC RESIDENTS Resident #1's toe and abdome is slowly healing and is free of infection at this time. Her Bracksessment and care plan has up-dated. OTHER RESIDENTS This practice has the potential all residents. Residents whom an injury have an assessment injury completed each shift in hours or until the condition in stabilized. Their physician are notified as required and the rendered as ordered. SYSTEMIC CHANGES License nurses were in-servitaccident/incident manageme assessments, wound docume identifying change of condition notification of physician and requirements on 6-23, 7-18 and requirements	of aden Risk s been al to affect a sustain of the or 72 as ad family reatment ced on ant, skin antation, ion, and family	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		135127	B. WIN	IG			; 2/2006
	ROVIDER OR SUPPLIER	DPOINT	1125 N DIVISION ST		EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	The resident was sand admitted to the treatment. It was dintravenous antibio. This failed practice the facility's Admin Consultant and the on 6/21/06 at 6:15 with specific details resulted in a seriou. On 6/22/06 at 12:4 surveyors with an and the immediate. The plan of correct. "1. Resident #1's vidocumented. Brad been updated. Call updated to reflect status. 2. All residents fee breakdown on 5/2: breakdown was id checks completed 6/22/06 and documented. 3. L.N.'s will be instanced and other terms of the corporation of Am Sores and Other terms.	ent to a local emergency room e hospital for evaluation and etermined she required tics for a diagnosed infection. I was brought to the attention of istrator, DON, Corporate Nurse Director of Medicare Services pm. The facility was provided of this deficient practice that is wound to resident #1. O pm the facility presented the acceptable plan of correction jeopardy was abated. Ition was as follows: Wound has been assessed and len Skin Risk Assessment has re Plan has been reviewed and residents current medical It were assessed for skin 3/06 and 5/24/06. No new skin entified. Head to toe skin on residents on 6/21/06 and mented on weekly skin check Serviced on LCCA's [Life Care derica's] Prevention of Pressure Ulcers Policy by 6/23/06.	F;	309	Nursing Assistants were in-se on identifying and reporting of in skin condition on 6-23, 7-17-19. Audits are performed weekly skin assessments are complet scheduled. Newly identified skin condition brought to the daily stand-up to ensure appropriate actions been taken. Skin and fall prevention in-seare scheduled quarterly. MONITORS ED and DON will monitor that attendance of the daily stand meetings and the monthly Planetings. DON and Resident Care Ma (RCM) will monitor through weekly skin assessment audit DATE OF COMPLIANCE:	to ensure ed as ons are meeting have ervices aroughup magers a the its.	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLET	red
		135127	B. WIN	IG _			2/2006
	ROVIDER OR SUPPLIER	DPOINT	STREET ADDRESS, CITY, STATE, ZIF 1125 N DIVISION ST SANDPOINT, ID 83864				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	residents. Resider Pressure Ulcer Pre Residents identifies skin breakdown, wand updated. To be LN's will be inserved documentation for Ulcers, and non-per All skin issues ideapprop. [appropria with documentation policy by 6/23/06 at Weekly head to to will be performed resident's individu. Assessment form Residents identified Diabetes will have completed by L.N. treatment sheets. reflect new interversident for initial Diabetic Foot Cheek Congoing LN inservice on procedure for initial Diabetes and Fernal Other Ulcers quartly [sic] for all	essments will be updated for all ats scoring 14 or below will have evention Checklist completed. It at moderate or high risk for will have Care Plan's reviewed e completed by 6/30/06. Iced on LCCA skin ms for Pressure Ulcers, Stasis ressure related skin on 6/23/06. Intified will be recorded on atel skin form, assessed weekly in until resolved per LCCA and ongoing. It is skin integrity assessments and documented on each all Weekly Skin Integrity by 6/22/06 and ongoing. It is weekly Diabetic Foot Checks and documented on individual Care Plans will be updated to ention by 7/1/06 and on-going. It is a completion of Weekly ecks. It is some completion of Weekly ecks. It is some completion of Wound Documentation, Complications Prevention of Pressure Sores on New Hire Orientation, and	F	309			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		135127	B. WING _		l .	C 2/2006
	ROVIDER OR SUPPLIER	DPOINT	1	REET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST SANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATI	ULD BE	(X5) COMPLETION DATE
F 309	Assessment and P Treatment Modaliti Newly hired L.N.'s during probationary 4. RCM [Resident of treatment sheets for Check Assessment forms sheets for completi D.O.N. by 7/1/06 at D.O.N. to do rando Integrity Assessment sheets Diabetic Foot Check Completic Foot Check Completic Foot Check Completic Foot Check Completic Foot Check Complete Tracking form and Tracking form	petencies on Pressure Ulcer ressure Sore Management es for each L.N. By 7/30/06. will complete competencies period. Care Manager] will audit or completion of Weekly sks, Weekly Skin Integrity, individual skin assessment on daily, with copy of audit to and ongoing. m audit of Weekly Skin ent forms, Individual Skin standard, and treatment sheets for sks by 7/1/06 and ongoing. LCCA Weekly Pressure Ulcer the Weekly Non-Pressure forward copy to D.O.N. by J. om chart audits for residents y acquired Pressure Ulcers to iffication, treatment plan and a compliance. om chart audit for new ure assessments, I treatments are approp. and reviewed by D.O.N. will be for performance improvement as CQI [Continuous Quality	F 309			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		135127	B. WING	i	1	C 2/2006
	ROVIDER OR SUPPLIER	DPOINT	1	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		2/2000
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	The Nurse Consult facility/available for is [name and credic [Idaho]). [Name of until [Name of Corcredentials (RN#2 [Name of Corporal started this process will monitor and in [Name of RN #1] with minimum of 3 wks of RN #2] has her the consultant if not the treating physical the resident's abdowith signs and syndeterioration. Findings include: Resident #1 was a diagnoses includir laparotomy for negotiating the consultant in the treating physical the treating physical the resident's abdowith signs and syndeterioration.	c." O.C. [plan of correction] tant that will be in the r consultation effective 6/22/06 entials of RN #1] (licensed in ID RN #1] will be in the facility porate Nurse Consultant and)] has received her ID license. te Nurse Consultant] has is today. The Nurse Consultant sure compliance of P.O.C. will remain in this capacity for a [weeks]. At that point if [name ID license then she will become of [RN #1] will remain until [RN	F 309			
	Resident #1 was a diagnoses includir laparotomy for negright pleural effusionacute abdominal psepticemia with mellitus, rheumato	ng s/p (status post) exploratory gative appendectomy, chronic				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUI)		;
.,		135127	B. WIN	<u> </u>		06/22	2/2006
	ROVIDER OR SUPPLIER RE CENTER OF SANI	DPOINT		11	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	resident had an operabdomen. a. A nursing note, or resident's admission assessment was as Large Callaces [side footHas ST [skin is dry & exposed as [with] redness note [right forearm] 1.5 minsertion site to [right approx[imately] 0.5 nursing note also did dressing over the residence. A "Weekly Skin Interested and as addition to the would assessment, the for "watery blisters on breakdown on the Nursing notes, date documented "Resignation of the slip strip toenail" Nursing am, documented "Committee reviewed which occurred 3/2 attempted to stand	admission to the facility, the en surgical wound to her dated 3/27/06, documented the en assessment and her skin in follows: "Skin intact [with] on the or lateral sides of each tear] to LFA [left forearm] that rea 2 x 1.5 cm [centimeters] defat] edges. Old ST to RFA to 0.5 cm. CT [chest tube] ht] lower chest wall from [with] sutures intact" The locumented the resident had a light lower quadrant of her egrity Assessment" form sessment, dated 3/27/06. In and identified on the admission or modeumented an area of [left] side" and an area of skin resident's buttocks. ed 3/29/06 at 8:45 pm, ident] stated she was trying to great a causing her toe to bleed at motes, dated 3/30/06 at 9:30 A & I [accident and incident] ed injury to [right] great toe 19/06 [at] 2000 [8 pm]. She by self & scraped toe on socks to be worn & reminded	F	809	DEFICIENCY		
	resident to use cal				,		

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STATEMENT OF DEFICIE! AND PLAN OF CORRECT!		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	CX3) DATE SURVEY COMPLETED	
		135127	B. WING			06/22/2006	
NAME OF PROVIDER OR		DPOINT		1	REET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
PREFIX (EACH	DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
notes or regarding injury. An incide 7:30 am, what occ resident's foul odor "When re [right] gre [with] yell tissue [af medial 2 documer was applia a local element of the inverse documer it as an "happen? documer toes on four toes on fou	ant and ac document urred where socks be was note emoving seat toe nailed toe [with the ted, and the wied, "Resturniture dent was a foot infect ve antibioous (IV) are summar wing: "Suppoccus sen Wethicillingsensitive to	ekly skin assessment forms ment or monitoring of the toe cident report, dated 5/23/06 at ted the following regarding in a visitor removed the ecause they were soiled and a	F	309			

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9.20 Cm

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A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER A. BUILDING C O6/22/2000		F CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COMPLE	TED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					IG	(c
OTTLET ADDICEO, OTT, OTATE, ZIE OODE			135127	B. WING _		06/2	2/2006
LIFE CARE CENTER OF SANDPOINT SANDPOINT, ID 83864			IDPOINT	1	125 N DIVISION ST		
	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
resident was receiving IV antibiotic therapy. A physician's progress note, dated 6/5/06, documented "I was asked to see [resident #1] today because her order for Vancomycin 1 gram Q [every] 48 hours for 14 days. Her right foot, for which the Vancomycin was ordered for Vancomycin 1 gram Q [every] 48 hours for 14 days. Her right foot, for which the Vancomycin was ordered fooks much better. Her great toe is no longer reddened but it does have a lot of eschar on the tip and an absent nail. I see a potential space under the eschar that leads down toward the bone. I don't know if it goes all the way to the bonel am going to continue the Vancomycin for another 2 weeks at 1 gram IV Q 48 hours." On 6/21/06, the facility provided the surveyors with an investigation report regarding the incident that occurred on 5/23/06. The investigation was dated 6/21/06 and documented the following: "On May 23, 2006, [visitor's name], Residents former personal caregiver at home was removing [resident #1's] socks when part of her right great toe nail came off during sock removal. [Visitor's name] then informed the team leader [name of LN], LPN what had just happened and also got Social Services Assistant [name] involved. [Social Services Assistant] famel involved. [Social Services Assistant] famel involved. [Social Services of corporate nurse consultant] of the incident. An incident who went to the Residents room, looked at the toe, covered it with a dressing and notified the Physician. She also notified [name of corporate nurse consultant] of the incident. An incident report was initiated. On 5/23/06 & 5/24/06 All Residents in the facility had their feet checked for any unidentified skin issues. There was no new skin breakdown noted.	res A do too ex Q who be do ab es kn to at Or with da "O for [restor na LN So se na Restor no the Or ha	resident was recei A physician's prog documented "I wa today because her expired. She was Q [every] 48 hours which the Vancom better. Her great to does have a lot of absent nail. I see a eschar that leads know if it goes all to continue the Va at 1 gram IV Q 48 On 6/21/06, the fa with an investigation that occurred on 5 dated 6/21/06 and "On May 23, 2006 former personal ca [resident #1's] soc toe nail came off on name] then inform LN], LPN what had Social Services As Services Assistant name], LPN of the Residents room, is a dressing and no notified [name of of the incident. An income On 5/23/06 & 5/24 had their feet check	ress note, dated 6/5/06, s asked to see [resident #1] r order for Vancomycin has ordered for Vancomycin 1 gram for 14 days. Her right foot, for lycin was ordered, looks much be is no longer reddened but it eschar on the tip and an a potential space under the down toward the bone. I don't the way to the boneI am going incomycin for another 2 weeks hours." cility provided the surveyors on report regarding the incident /23/06. The investigation was documented the following: (visitor's name), Residents aregiver at home was removing ks when part of her right great luring sock removal. [Visitor's ed the team leader [name of dijust happened and also got esistant [name] involved. [Social of the physician. She also corporate nurse consultant] of cident report was initiated.	F 309			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKDX11

Facility ID: MDS001420

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50 07-17-06

PRINTED: 07/06/2006 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		135127	B. WIN	1G_		06/22/2006	
	ROVIDER OR SUPPLIER	DPOINT	STREET ADDRESS, CITY, STATE, ZII 1125 N DIVISION ST SANDPOINT, ID 83864				
(X4) ID PREFIX TAG	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	needed. Residents the past week wershower. On 5/23/06, Facilit or neglect was init contacted [physicis of [resident #1's] gat that time the inf Hematogenous intopen abd [abdomithat this was from On 5/24/06 [name interviewed staff resident #1], all sinterviewed staff resident #1], all sinterviewed staff open wounds on into remember seelist of staff that we names] After chart review neglect could not Facility Managem training needs of training plan/ scheher position on 5/0 On 6/21/06 Interviewed of the position of 5/0 on 6/21/06 Interviewed of the position of 5/0 on 6/21/06 Interviewed of the position of 5/0 on 6/21/06 Interviewed of 5/0 on 6/0	if Podiatrist evaluations were that had not had a shower in e identified and received a sy investigation to rule out abuse iated Executive Director [name] an's name] to find out the status great toe, he [the physician] felt ection was part of a possible fection that spread from her inal] wound, and he did not feel abuse or neglect. If of Executive Director] members who provided care to taff members that were in that they did not remember any ner right great toe & most could be in the right great toe and staff interviews abuse and be substantiated. If and staff interviews abuse and be substantiated. If and staff members and develop a edule when new DON started		309			
	making any progi work with her, [re	ress so 01 did not continue to esident #1] did stub her right					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKDX11

Facility ID: MDS001420

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S.Bolen 20 01-17-06

PRINTED: 07/06/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1	IULTIP ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		135127	B. WII	4G		1	2/2006	
	ROVIDER OR SUPPLIER			11:	EET ADDRESS, CITY, STATE, ZIP CODE 25 N DIVISION ST ANDPOINT, ID 83864			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1X	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	ACTION SHOULD BE COMP TO THE APPROPRIATE D		
F 309	and oozing, [namat that time and that time and that time and that applying a dressing of the resident's barnonth of May 200 shower was on 5/documentation in she had been bat between 5/2/06 a transported to the polymicrobial toe. The bath record of the occupational on 4/7, 4/10, 4/11 and 4/28/06. Weekly skin assection of the documentation to had been perform assessments corpertaining to the An interview was the RN Director of the An interview was the RN Director of Medicino injury to follow nursing notes for and bleeding. In noticing the wour "I know that she is the state of the sta	nat time and the toe was bruised e of OT] did notify [name of LN] nat [name of same LN] was ng." th records were reviewed for the 06. The only documented 12/06. There was no other the resident's record to indicate thed or showered any time nd 5/23/06 when she was a emergency room for the	F	309				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKDX11

Facility ID: MDS001420

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D. Bolan 20

PRINTED: 07/06/2006 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		135127	B. WI	IG		06/22/2006	
	ROVIDER OR SUPPLIER	IDPOINT		11	EET ADDRESS, CITY, STATE, ZIP CODE 25 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ULD BE	(X5) COMPLETION DATE	
F 309	to remove her soci "shocked" when so 5/23/06. The facility failed is monitor this reside she developed a prequiring hospitalitopical, and intravin serious harm to immediate jeopar caregiver visiting wound on the restoe which require antibiotic treatmedocumentation of this diabetic resident received month of May price 5/23/06 and the leassessment was documentation in therapy notes to bruised and oozinfacility's investigated. At the time of a #1 had an open a an exploratory lay re-opened during when the laparote wound contained any organisms of	entifying the resident's refusals exs. The RN stated she was he saw the toe wound on to adequately assess, treat and ent's injury causing harm when colymicrobial infection in the toe zation and treatment with oral, enous antibiotics. This resulted the resident, constituting dy. On 5/23/06, a private the resident, discovered a ident's right great toe and 2nd d hospitalization and aggressive ht. The facility had no ongoing foot assessments for ent, there was no follow-up for a farch, bath records revealed the only one shower during the or to her hospitalization on ast documented skin on 5/7/06. There was no the nursing or occupational ndicate the resident had a ng right great toe except in the tion report dated 6/21/06. Admission on 3/27/06, resident abdominal wound as a result of parotomy incision that had to be a recent hospitalization. The esummary documented that the comy incision was re-opened, the clear fluid and "did not grow in culture." The resident was a facility with orders for wound	F	809			

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Event ID: IKDX11

Facility ID: MDS001420

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9.30 Can 20 07-17-06

PRINTED: 07/06/2006 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		135127	B. WIN	₩G		C - 06/22/2006		
	ROVIDER OR SUPPLIER	DPOINT		1′	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ULD BE	(X5) COMPLETION DATE	
F 309	Continued From pa	age 26	F;	309				
	Nursing notes regather following:	arding the wound documented						
		· "Abd [abdomen] large, soft, g] over RLQ [right lower						
	side 3 cm [centime Dressing [changed wound cover] appl	"Res[ident] incision on [right] eters] long [with] gauze packing. I] ABD [type of absorbent ied. Lg [large] amt [amount] of es started on 500 mg Keflex for						
		- "Dressing was saturated ro sanguinous drainage and						
	adipose tissue exp serous drainage, [- "Wound bed pink [with] posed. Moderate amounts of no] odor noted. Edges pink is or symptoms of]						
		- "Dressing was [changed] on & NS [normal saline] applied to D pads covered"						
	wound care. Area [dressing] had cor	- "Con't [continue] [with] cleaned [with] NS, old dsg bious amounts of serious [sic] r noted. Area covered [with] dry	·					
	*3/30/06 10:30 pm packing in place	n - "Abdominal wound - "					***************************************	
l							<u> </u>	

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Event ID: IKDX11

Facility ID: MDS001420

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILI			IPLE CONSTRUCTION	COMPLETED C			
		135127	B. WIN	4G _			/2006
	PROVIDER OR SUPPLIER	DPOINT	STREET ADDRESS, CITY, STATE, ZIP CO 1125 N DIVISION ST SANDPOINT, ID 83864				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE		ULD BE	(X5) COMPLETION DATE
F 309	*3/31/06 3:15 pm - quadrant] con't to h [sic] drainage [with *4/1/06 2:50 pm - "continues to have sheen changed" *4/2/06 4:00 am - "gray marbled [with] *4/4/06 1:45 pm - "drain large amount open [with] adipose or s/sx inflammatio *4/6/06 3:00 pm - 'moderate to large Old dsg has slight *4/7/06 3:50 pm R moderate to large Wound lower edge exposed adipose to 'fishy' odor"	"Incision to RLQ [right lower have large amounts of serious out] odor" "Incision to the RLQ serous drainage. Dressing has "Abd[omen] wound tissue is] yellow adipose tissue" "Abd wound to RLQ con't to to of serous drainage area e tissue exposed. [No] redness on [at] site" "RLQ wound con't to have amount of serous drainage. 'fishy' odor" LQ wound con't to have amount of serous drainage. e dry & brown. Wound bed is all issue. Wound con't to have "RLQ continues to have of serous drainage. It also have	F:	309			
	*4/9/06 1:00 pm - RLQ requires wet done. The area ar hard to the touch, minimal serous dr	"Abd wound located on the to dry dressing which was ound the wound feels a little there was minimal odor today,					

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J. Dola 20

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		135127	A. BUILDIN	NG	06/22	; /2006
	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1125 N DIVISION ST SANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	Lower aspect of we about wound statu. *4/11/06 2:30 pm - cm x 3.0 cm & 7.5 yellow. Copious an [treatment] wet to day. Wound edges Edges are again b surrounding area *4/11/06 9:20 pm - purulent pus. Black order [sic]" *4/12/06 2:10 pm - copious amounts of Very foul odor conhas exposed adipwound is black & district wound is black & district wound - soaked w/normal saline. We wish wound on R cleaned from botto 4/14/06 4:00 pm - wound con't to ha	bund black & dryMD faxed s" "[right] abd surgical site 12.3 cm depth. Tissue gray & nt odorous drainage. Tx dry increased to 3x [times] a sidebreaded [sic] on 4/4/06. lack & tender [with] reddened ." "Wound was filled [with] k around outer edges. Has an eliming from wound. Wound bed ose tissue, lower aspect of dry" - "Wound was full of purulent eliming purulent drainage lying if up by 4 x 4's and cleansed eliming covered digodor." "Dressing [change] completed LQ. Purulent, foul smelling pusom of wound" "Late entry for 4/13/06Abd ve copious amounts of purulent oul odor. Outer, most inferior	F 309			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		135127				06/22	1
	ROVIDER OR SUPPLIER			11	EET ADDRESS, CITY, STATE, ZIP CODE 25 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 29	F	309		·	
	*4/14/06 4:00 pm - remains unchange returned today fax	"Abd wound assessment d from 4/13/06Wound culture ed to MD"		***************************************			
	isolation precautio evening-[increase than last evening a	"Resident moved to roomfor ns. Dressing change this d] drainage on dressing - more approx[imately] 30 cc [cubic ulent & [increased] odor"					
	faxed concerning of fax 'No antibiotic be to 3x's daily which resident's physicial afternoon of lab re	- "[name of surgeon] was description of wound - return but to increase dressing change is being done. [name of an] faxed at 2 pm yesterday esultsDressing changed this es to have purulent drainage					
	putrid odor, copiou yellow/gray draina site [with] gray wo	- "Surgical site RLQ has us amts [amounts] of age. Necrotic tissue at bottom of und bed. Area surrounding m & hard to the touch"					
	surgical wound. P noted in dressing, dressing copious surface [sic] on the clean the excess emitted from the	- "Changed dressing to RLQ turulent yellowish drainage also after removing old amount of the same drainage wound bed. Use sterile 4x4 to drainage x2. Strong foul odor wound. Dressing was changed [at] 2:00 pm it was leaking					
	*4/16/06 3:30 pm w/new order. ATE	- "[name of physician] called 3. [antibiotic] Levaquin 250 mg					

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Facility ID: MDS001420

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8, Bola 20 07-17-06

PRINTED: 07/06/2006 FORM APPROVED OMB NO. 0938-0391

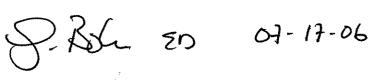
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILD B. WING		C	- 1
		135127			06/22	/2006
	ROVIDER OR SUPPLIER RE CENTER OF SANI	DPOINT	S	TREET ADDRESS, CITY, STATE, ZIP CODE 1125 N DIVISION ST SANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	Continued From page [milligrams] qd [everead symbol] wound Physician's progres following in referent *4/3/06 - "she has the right lower qualified already been clear reddened or with his she has no increase *4/10/06 - "she dabdominal pannus whether or not the antibioticsThe abstract They have aggressively. She but it's not looking I am not going to or add antibiotics A physician's orde "Culture Abd wourd The results of the identified the reside infected with Protes Pneumonia, and Eresident began or add symbol symbol."	age 30 ery day] x5 days [unable to ad infection" es notes documented the ace to the abdominal wound: s a fair amount discharge from drant wound. Today this is ned and does not look age amounts of exudate and sed abdominal swelling" eveloped some redness in her am here today to see re is any reason to start odominal folds now look much been cleaning them does have a drapery of tissue cellulitic right nowSo for now, change any of her medications ." r, dated 4/11/06, documented, add" wound culture, dated 4/15/06, lent's abdominal wound was seus Mirabilis, Klebsiella Enterococcus Faecalis. The all antibiotic treatment on	F 30			
	document further surgeon examined ordered the reside	n 4/16/06 through 5/2/06 deterioration of the wound. The d the resident on 5/2/06 and ent to be seen by a wound ement of a wound vacuum (vac)				

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Event ID: IKDX11

Facility ID: MDS001420

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PRINTED: 07/06/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		135127	B. WING _		C 06/22/2006	
	ROVIDER OR SUPPLIER	POINT	1	REET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST SANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTION	
F 309	Continued From page 31 The facility failed to adequately assess, monitor, and notify the treating physician in a timely manner when the resident's abdominal wound first presented with signs and symptoms of wound infection and deterioration. Nursing notes document a "fishy" smell from the wound on 4/6/06 and continued to document the presence of a foul odor with subsequent dressing changes. The resident's physician was not notified until 4/10/06 and a wound culture was not ordered until 4/11/06. Antibiotic treatment did not begin until 4/16/06, a full 10 days after the wound began to show evidence of infection and deterioration. This delay in treatment resulted in harm to the resident; her abdominal wound was infected with Proteus Mirabilis, Klebsiella Pneumonia, and Enterococcus Faecalis, required antibiotic treatment and eventually a wound vac. When the		F 309			
F 312 SS=E	hospitalization iden non-healing abdom complaint investiga still required the us 483.25(a)(3) ACTIVA resident who is u daily living receives maintain good nutriand oral hygiene.	/ITIES OF DAILY LIVING nable to carry out activities of the necessary services to tion, grooming, and personal	F 312	F-312 SPECIFIC RESIDENTS Resident #1 receives baths as scheduled. OTHER RESIDENTS		
	by:	NT is not met as evidenced view, review of resident		This practice has the potential all residents. Residents receive as scheduled.		

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S. Bolen 20 07-17-06

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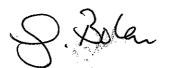
CENTERS FOR MEDICARE				: II T:	PLE CONSTRUCTION	(X3) DATE SURVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI			COMPLET	
						C	ŀ
		135127	B. VVII			06/22	/2006
	ROVIDER OR SUPPLIER	DPOINT		1	REET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
			•	3	PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIES OF MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
F 312	Continued From pa	age 32	F	312	SYSTEMIC CHANGES		
	from the public, it was not ensure resident a timely manner. The residents (#1) and	aff interview, and complaints was determined the facility did ts received baths or showers in this affected 1 of 1 sample random residents who council meetings in May and gs include:			A protocol has been develope ensure that bath aides are not pulled to the floor during staf shortages. A new bath schedule has been	routinely f	
	1. Resident #1 was admitted on 3/27/06 with diagnoses including s/p (status post) exploratory laparotomy for negative appendectomy, chronic right pleural effusion, congestive heart failure, acute abdominal pain, streptococcal bacteremia, septicemia with mental status changes, diabetes mellitus, rheumatoid arthritis, atrial fibrillation, coronary artery disease, and chronic renal insufficiency. Upon admission to the facility, the resident had an open surgical wound to her abdomen.				implemented to ensure all resare schedule for baths at least times weekly. Personal prefet for baths are scheduled as recall the scheduled as recall t	t two erences quested.	
					Staff was in-serviced on ensunecessary activities of daily services are provided as sche 7-18 and 7-19. This includes	living eduled on	
	The resident's hat	h records were reviewed for the			MONITORS		
	month of May 200 shower was on 5/2 documentation in she had been batt	The resident's bath records were reviewed for the month of May 2006. The only documented shower was on 5/2/06. There was no other documentation in the resident's record to indicate she had been bathed or showered any time			RCM's will monitor through bath audits.	weekly	And the second s
		nd 5/23/06 when she was emergency room for a nfection.			DON will monitor through rethe bath audits.	eview of	
	reviewed for the n	2. Resident Council meeting minutes were reviewed for the months of May and June 2006. The minutes, dated 5/15/06, revealed the			Staffing Coordinator will me through scheduling of Bath		The state of the s
	following documentation, "1) C/O [complaints of] shower being done hit & miss" According to documentation, 10 residents attended the May meeting.				ED will monitor through the PI meetings and concern corprogram.	•	
	The June minutes	, dated 6/14/06, documented			DATE OF COMPLIANCE:	7-25-06	

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Event ID: IKDX11

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20 07-17.06

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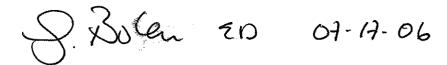
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		135127	B. WING _			C 2/2006
	ROVIDER OR SUPPLIER	DPOINT	1	REET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST SANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 312	the following in the minutes, "1) C/O s still on going proble section of the minus showers not being According to docur the June meeting. An interview was of 6/22/06 at 10:55 a she arrived at the shift, she was ofter as a CNA for the dwas reassigned, shower only 1 resists of residents may and that this occur identified one residentified as a shower the aide acknowled period in May whe shower. She state short-staffed and "we're hurting" On 6/22/06 at app interview was considered as a bath a past 2 months. She bath aide, she wouther floor as a CNA were about 8 showers.	age 33 "Old Business" section of the howers being done hit & miss em." The "New Business" attes documented, "2) C/O given on a regular basis" mentation, 9 residents attended conducted with a bath aide on m. The aide stated that when facility at the beginning of her in reassigned to work on a unit lay. She noted on the days she he may have been able to dent. She acknowledged that lay go 6 to 8 days without a bath is on a regular basis. She dent she had bathed that day, bathed in 12 days. She stated wed at work, she was handed a lat were in "critical" need of r. In reference to resident #1, dged that there was a long in the resident did not receive a did the facility was currentlyif someone calls in sick, roximately 11:20 am, an ducted with a CNA who had laide in the facility within the e stated that when she was the laid often be reassigned to work as She acknowledged that there were to do per shift and the me to do 2 or 3 when there is	F 312			

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTI LDIN		(X3) DATE SURVEY COMPLETED	
		135127	B. WI			oeini Oeini	2/2006
	ROVIDER OR SUPPLIER			1	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864	U0/ <i>&</i>	2/2006
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
	baths or showers in was not showered transported to the h polymicrobial infect	ensure residents received a a timely manner. Resident #1 for at least 21 days and was cospital on 5/23/06 for a ion in her toe.		312			
F 314 SS=D	Based on the compresident, the facility who enters the faci does not develop produced individual's clinical they were unavoidable pressure sores recessives to promote prevent new sores. This REQUIREMED by: Based on record recomplaint from the facility did not prevent new sores form developing. The facility did not prevent new sores form developed a pressure some some some some some some some som	prehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that lible; and a resident having eives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced view, staff interview and a public, it was determined the ent a Stage 2 pressure ulcernis was true for 1 of 1 resident ressure ulcers. The resident ure ulcer to the inner aspect of left foot secondary to tight	F:	314	F-314 SPECIFIC RESIDENTS Resident # 9 was discharged from facility and a closed record. OTHER RESIDENTS This practice has the potential to all residents. Residents who has assessed to be at risk for skin breakdown have preventive me implemented and care planned. Weekly skin assessments are performed to identify skin issue they may be addressed timely. Physician who request podiatry appointments for residents will them scheduled as ordered and resident and family allow.	to affect ve been easures . es so y I have	

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Event ID: IKDX11

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PRINTED: 07/06/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
74101 0410			A. BUILDIN	VG	С		
		135127	B. WING_		1	2/2006	
	ROVIDER OR SUPPLIER	DPOINT	1	REET ADDRESS, CITY, STATE, ZIP CODE 1125 N DIVISION ST SANDPOINT, ID 83864			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE 3-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 314	physician, documer receive a Podiatry (LN noted the physician) noon. There was no docuresident's record the consult for the resident's record the consult for the resident's for the develope each assessment. The admission numidentified the resident feet. The note on 2/12/0 developed a Stage of her 5th toe on he measured 0.4 x 0.2 hydrocolloid dressing. The transport of the examined to ordered an antibiot assessed the wour contributing factors fitting shoes. Resident and the examined of the examined of the examined the	inted the resident was to Consult for nail/callus care. An cian order on 4/13/05 at 12:00 imented evidence in the lat the facility obtained this ident. In was performed on 4/13/06 and and and the resident scored as low iment of pressure ulcers at increased real three services. And the medial aspect in the resident on 2/14/06 and and identified the resident on 2/14/06 and inc. The facility's wound team and and identified the swere her diabetes and "poor lent's shoes changed." The that the toe appeared less drainage or pain. The wound	F 314	Diabetic foot check stickers a on the weekly skin assessment of the diabetic residents to enstaff pay particular attention the feet when assessing the skin. Weekly audits are performed the weekly skin checks are down the weekly skin assessments of 7-18 and 7-19. MONITORS RCM's will monitor through weekly skin assessment audit DON will monitor through raweekly audits of skin assessment he skin tracking logs. ED will monitor through the PI meeting. DATE OF COMPLIANCE: 1	to ensure one. pleting on 6-23, the s. ndom nents and		
		m documented, "Healing ST esolvedless than 0.5 cm in					

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07-16-06

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUI	LDIN	NG		c
		135127	B. WIN	IG _		1	2/2006
	ROVIDER OR SUPPLIER RE CENTER OF SANI	POINT		1	REET ADDRESS, CITY, STATE, ZIP CODE 1125 N DIVISION ST SANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 36	F 3	314			
	had resolved. The I discontinued and a initiated to be applie times daily for 14 discomfort to the arrangement of the area on the resiresolved and the trebarrier film continues shoes remain off. In discomfort." The Annual MDS at 4/17/06, documented wound remained clutreatment of the barrier of the barrier film continues shoes remain off. In discomfort." The Annual MDS at 4/17/06, documented wound remained clutreatment of the barrier of the wound in the barrier of the barr	team note on 3/9/06 identified ident's 5th toe remained eatment plan of No Sting ed to be effective. "The tight desident denies any pain or essessment note, dated ed the resident's 5th toe cosed and the protective rrier film would continue. It performed foot their residents. The note by a not team documented, essed. Noted toe nails thick - c. Faxed MD for request for a feet issues noted. Resident					
		ote, dated 6/1/06, documented I after a recent decline in her					
	The Director of Med	dicare Services was		:			

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STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF		DATE SURVEY COMPLETED
		135127	B. WING		06/22/2006
	ROVIDER OR SUPPLIER	DPOINT	11	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 314	she would look for consult was perfor She was also askeresident's feet had basis since her ad 2005. At 3:00 pm acknowledged the scheduled. Also, tassessments perform who had a history nails. The DON was als She acknowledge initiated when the her 5th toe. The facility failed shoes for appropriadmission to the The resident work fitting" causing a approximately ter the facility. 483.25(h)(2) ACC. The facility must receives adequated evices to prevent	evidence that the Podiatry med as ordered on 4/13/05. The determinant of the provide evidence that the been monitored on a routine mission to the facility in April the same day, the Director Podiatry consult had not been here were no routine foot ormed on this diabetic resident of calluses, corns and mycotic or interviewed earlier in the day. It is a monitored an investigation had not been resident developed the ulcer to to assess this diabetic resident's facility and at regular intervals. The shoes which became "tight pressure ulcer to one of her toes a months after her admission to consider that each resident e supervision and assistance at accidents.	F 314	F-324 SPECIFIC RESIDENTS Resident # 8's is working with physical therapy services on a transport a merry walker. The following for prevention measures continue to implemented: Offer activities when restles Take for short walks when results Low bed Mat at bedside Pressure alarm in bed and working the chair Notify family to visit when Family and resident choose not have 1:1 sitters at this time. The continue to be undecided as to placement in the secure unit. The	fall be s restless wheel restless to ey
	by: Based on review	ENT is not met as evidenced of the facility's Incident/Accident orts, interview, and three		have been educated related to the of frequent falls and wish to conwith current measures at this time.	ne risk ntinue

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION (X3) DATE SURVI COMPLETED		
		135127	B. WIN			06/22) 2/2006
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1125 N DIVISION ST SANDPOINT, ID 83864		125 N DIVISION ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 324	complaints from the facility did not ensuadequate supervise affected 2 resident resident Incident/A Resident #8 fell from the course of 52 did wheelchair, was for building in the part 2006, and once in by an off-duty empto work, and by a selection by an off-duty empto work, and by a selection of the selection o	e public, it was determined the ure residents received ion to prevent accidents. This is (#8 & 16) of the 3 months of accident reports reviewed. If the sover ays. Resident #16, while in his and outside the facility's king lot, three times in April June 2006. He was found once ployee, by an employee arriving staff member who happened to a facility window. Findings admitted to the facility on oses which included arthritis, kinson's disease. Her seessment, dated 2/7/06, esident was moderately ion, required one person bed mobility, transfers, and on her unit in the facility. Her occomotion was the wheelchair. Eady. The test for balance physical support during test or oes not follow directions for istory of falls 30 and 31-180 admission to the facility. The grered as "Fall Risk." The proceed with care planning for 65, dated 5/4/06, documented become severely impaired and a 2-person physical assist for diffallen in the past 30 and	F	324	Resident # 16 has been transit the secure unit to prevent furt elopement. OTHER RESIDENTS This practice has the potential all residents. Residents who is sustained a fall in the past 90 care plan has been reviewed added if necessary to ensure for prevention measures have been implemented. SYSTEMIC CHANGES Staff was in-serviced on fall prevention, care planning and accident/incident forms on 7-7-19. A new resident fall intervention tracking form has been implemented. The accident/incidents are brother daily stand-up meetings for the daily stand-up meetings for the daily stand-up meeting and recach incident for completion. DATE OF COMPLIANCE:	I to affect have days and up- all en I the new 18 and on emented. ought to for review	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1`'	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		135127	B. WIN	IG		06/22	; 2/2006	
	ROVIDER OR SUPPLIER	DPOINT		11	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 324	Continued From pa	age 39	F3	324		AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA		
	"20". A score of 10 risk, according to the Review of the facil Investigation report June 2006, docum *4/26/06 at 9:30 ar [wheelchair] landing attempts to stand agitation & aggres witnessed? NoTo standWhat improvide safety for to [assist] res[iden alert charting q [evitalls alarm soundir long was the resid was found? Immediated to the stand to the s	on 4/6/06 and 5/12/06 was or above represented high he facility's form. ity's Incident/Accident ts (I/As) from April through mid ented the following: m, "Slid forward out of w/c g on knees. Has had multiple (without) A[ssist] [Increased sivenessWas the incident type of injury: noneattempting mediate actions were taken to resident and/or others? Attempt ti] [with] activity, also toileted, rery] shift x 72 [hours]Was ng? YesApproximately how ent on the floor before he/she diatley [sic]When was the by staff, and by whom?" This						
	sitting on floor in a alarm going off. M report documented the resident sustal "sitting in w/c tryin immediate actions redirect for activiting floor a "few minuted There was no time resident was last stated."	m, " Res[ident] was found nother res room [with] falls ultiple attempts to stand" The d the fall was unwitnessed and ined no injury. The resident was g to stand". The facility's were, "Falls alarm in chair es." The resident was on the es" before she was found. e of day listed as to when the seen by staff. am, "Resident stood out of e needed to go to BR						

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUIL			c l
		135127	B. WIN	G	06/2	2/2006
	ROVIDER OR SUPPLIER	POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 N DIVISION ST SANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 324	[bathroom]. She losinjury" The fall wadid not identify the fall wadid not identify the fall seen by staff. Tolleted, alert charresident was found nurses' notes, date [No] [urine] dip [test Will obtain urine dippattern of elimination with the resident of the resident. The land rail lost her bathere was no injury by staff. There were actions taken by the the resident. The land documented on 5/2 secured unit placer stim[ulation] surrou with the resident. The land lowered self to floor unwitnessed. There seen by staff, "10 mactions taken by the The land meeting reversion of the land meeting reversion of the land meeting reversion." *6/16/06 at 10:30 at knees x 2 in LT [lorattempting to stand incidents were not vinjuries. The immediate charting every shift identify when the resident in th	at her balance & fell [without] as unwitnessed and the report time of day the resident was the immediate actions were, ting q shift x 72 [hours]." The "immediatley [sic]." The d 5/15/06, documented, " t] obtained @ time of incident. to Will attempt to establish a ton for toileting schedule" Immediate was witnessed and the floor" The incident was witnessed and documented immediate a facility to provide safety for a meeting review notes 4/06, " Will assess for ment to provide low notings." Immediate was a manifer to provide low notings." The incident was a was no injury. She was last ninutes ago." The immediate a facility was, "Re-directed." view notes documented on use] to work towards placement	F3	24		

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2D 07-17-06

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION 3.	(X3) DATE SURVEY COMPLETED C	
		135127	B. WIN	IG			2/2006
	ROVIDER OR SUPPLIER			11	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH' CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 324	Continued From p "Will attempt to w a walk to dine sch participate in exel updated." On 6/22/06 in the provide additional received increase resident continue and fall. The DON department docu the resident to the these notes would documentation of available. The social servic documented, "Sist does want to put Unit] does not was Sister will not be obligations and w transition. Sister to complete rm [r involvement [with one to tell & expl [increased] risks the move knowin wait."			324	DEFICIENCY)		
	interviewed on 6 facility started the program after the extra supervision activities." The factors activities.	redicate Services was /22/06 at 2:07 pm. She stated the resident on the "walk to dine" 6 6/16/06 falls. "Activities is doing a & decreased stimulation acility did not provide any dence to the investigation team.					

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		135127	B. WII	NG		1	C 2/2006
	PROVIDER OR SUPPLIER	POINT		11	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 324	The social service of 6/19/06 that the deto not agree to tranunit at that time, wat increased risk. The facility failed to when the resident sattempts to stand falls from her whee resident resided in increased staff sup. 2. Resident #16 wat 12/31/01 with diagramellitus and depresed this most recent quidentified he was monognition, and requiassist for transfers wheelchair was his transportation. Review of the facility Investigation report June 2006, document was at 1:30 pm arrived to work she stated, 'I just wanted device in use at the [wheelchair]What to provide safety fo Returned to facility the section, ELOPE	staff member documented on cision by the resident's sister sfer the resident to the secure is possibly placing the resident increase staff supervision started to make "multiple and had repeated unwitnessed lichair. As of 6/22/06 the the same room and without ervision. Is admitted to the facility on coses which included diabetes sision. Farterly MDS, dated 3/22/06, oderately impaired in ired one person physical and locomotion. The primary mode of	F	324			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	ULTIPL LDING IG	E CONSTRUCTION	COMPLE	TED
	ROVIDER OR SUPPLIER	DPOINT		112	ET ADDRESS, CITY, STATE, ZIP CODE 5 N DIVISION ST NDPOINT, ID 83864	00/22	2/2006
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 324	absence: 5 min[ute found? Parking lot see the resident? was no signature/of to verify the invest. *4/18/05 at 1:50 proparking lot & was incident witnessed incident: Attempting assistive devices wincident? W/CW taken to provide see Returned to room, q shift x 72 [hours section, the follow "Approx[imately] 5 person to see the the circumstances Res attempting to "It looks nice out to signature/date by the investigation will less than thirty minicident, which do facility & engaged *4/27/06 at approximated to resident assistive of the incident? We were taken to provothers? Brought be re[garding] [positions to the provothers? Brought be represented to the provothers? Brought	es] Where was the resident. Who was the last person to "This was left blank. There date by the Executive Director igation was complete. m, "Resident outside in returned to facility Was? NoActivity at the time of the last to elopeWhat resident were in use at the time of the last immediate actions were afety for resident and/or others? A[ssisted] to bed, alert charting a]" Under ELOPEMENT ing was documented: ation of resident's absence: min[utes] Who was the last resident? UnknownDescribe a surrounding the elopement. In go outside because he stated, where." There was no the Executive Director to verify was complete. This incident was not the safter the 11:00 am cumented he was, "Returned to	F	324			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		135127	B. WI	IG_	A part of the state of the stat	1	2/2006
	ROVIDER OR SUPPLIER	DPOINT		11	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 324	absence: Unsure 5 last person to see room staff. Describ surrounding the element bridge entran reception area" I the Executive Direwas complete.	5-10 minutesWho was the the resident? Dinning [sic] be the circumstances opement: Resident was found ce by off duty staff & return to There was no signature/date by ctor to verify the investigation	F	324			
	large bruise [with] [right forearm]W NoActivity at the UnknownWas ar involved? No. Whataken to provide sa others? Alert chart [hours.]"Under S following was docu Unknown. Who wa This was left blank equipment? Unknowninvestigation?" Thi signature/date by the investigation wand large skin teal	m, "During AM cares noted large ST [skin tear] to RFA as the incident witnessed? time of the incident: nother resident or associate at immediate actions were afety for resident and /or ting q[every] shift x 72 skin RELATED INJURY the umented: "How did it happen? as involved in alleged injury?" k. "Did the injury involve ownWas there an is was left blank. There was no the Executive Director to verify was complete. The large bruise rewere found less than 24 hours was outside the facility and					
	resident out in par incident. Res state new set of wheels This was left blank incident: Attemptir facility & [increase	am, PT [physical therapist] saw king lot & returned him [without] ed that he was 'looking for a 'Was the incident witnessed?" k. "Activity at the time of the ng to leave facilityReturned to d] supervisionUnder the ENT, the following was					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ILTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILI			c l	
		135127	B. WING	<i>i</i>	06/2	2/2006	
	ROVIDER OR SUPPLIER RE CENTER OF SANI	DPOINT .	5	STREET ADDRESS, CITY, STATE, ZIP CODE 1125 N DIVISION ST SANDPOINT, ID 83864			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPOPER DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
F 324	documented: "Apprabsence: Minutes see the resident? Uresident found? Semember" The 6/13/06 I/A inversident found? Semember" The 6/13/06 I/A inversion to parking lot wiset of wheels', Action facility. Follow-Up: Verule-out] UTI [urinator outside area" sign/date either form. The nurses' notes of 6/13/06 at 10:00 prevening. Pleasant & 6/14/06 at 10:15 and on 6-13-06 at 1300 outside in parking leconfusion will requed offer patio for his outside in parking leconfusion will requed offer patio for his outside in parking leconfusion will requed offer patio for his outside in parking leconfusion will requed offer patio for his outside in parking leconfusion will requed offer patio for his outside in parking leconfusion will requed offer patio for his outside in parking leconfusion will requed offer patio for his outside in parking leconfusion will requed offer patio for his outside in parking leconfusion will requed offer patio for his outside in parking leconfusion will requed offer patio for his outside supervision will requed offer patio for his outside supervision will requed offer patio for his outside supervision will request the form of th	oximate duration of resident's a Who was the last person to linknown. How was the en out window by staff estigation report was the only ed the form, Incident amendation. It documented: tigative Facts: Resident went thout assist, 'looking for new ons taken: Brought back to Will dip [test] urine r/o ary tract infection] & offer patio The Executive Director did not m. documented the following: a, "[No] elopement this a cooperative [with] cares" a, "A/I review mtg [meeting] - [1:00 pm] res was found of and showed [increased] est dip for UA[urinalysis] & utside needs." estigation report identified, vision." There was no available the facility provided the on after this or the previous resident was found in the	F 32				
	regional Vice Prese	eximately 6:30 pm, the facility's ent was advised of the sabout the facility's lack of					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		135127	B. WING		1	2/2006
	ROVIDER OR SUPPLIER	DPOINT	9	STREET ADDRESS, CITY, STATE, ZIP CO 1125 N DIVISION ST SANDPOINT, ID 83864	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 324	thorough investigat adequate supervisi safety, particularly multiple times outs	tion of the I/As and the lack of ion to maintain residents' resident #16 who was found ide the facility. As of this has not provided any additional	F 32	24		
F 353 SS=G	The facility must he provide nursing and maintain the higher and psychosocial videtermined by resignidividual plans of the facility must provide and personnel on a 24-care to all residents care plans: Except when waive section, licensed mersonnel. Except when waive section, the facility nurse to serve as a duty. This REQUIREME by: Based on staff inte	ave sufficient nursing staff to derelated services to attain or st practicable physical, mental, well-being of each resident, as dent assessments and care. Tovide services by sufficient of the following types of thour basis to provide nursing in accordance with resident of the dunder paragraph (c) of this the surses and other nursing of the dunder paragraph (c) of this must designate a licensed of charge nurse on each tour of the tou	F 35	SPECIFIC RESIDENTS Resident #'s 1, 8 and 16 a sufficient staff to provide related services to attain the practicable physical, ment psychosocial well-being. bathing assistance, superverse prevent falls and provision required services and assess OTHER RESIDENTS This practice has the poterall residents. All residents provided sufficient nursin related services to attain the practicable physical, ment psychosocial well-being. bathing assistance, superverse falls and provision required services and assesses.	nursing and neir highest ral, and This includes ision to a of nursing saments. Intial to affect are g staff and heir highest ral, and This includes rision to a of nursing	

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Event ID: IKDX11

Facility ID: MDS001420

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S. Lola 20 07-17-06

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NOMBER.	A. BUII	LDING		l c	;
		135127	B. WIN	IG			/2006
	ROVIDER OR SUPPLIER	DPOINT		11	EET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 353	facility did not ensuprovided to meet in residents in the foll failed to adequately resident's injury care developed a polymore requiring hospitalizy resulted in harm, of to the resident. The assess, monitor, a physician when he show signs and sy deterioration. This resident. The facility received baths or a failed to provide accessive devices that affected 1 of 1 sarresidents (#8 & 16 attend Resident Country June 2006. Finding a. Resident #1 was diagnoses including laparotomy for negright pleural effusion acute abdominal proposed insufficiency. Upon resident had an opabdomen. The facility failed to the facility failed to meet the fai	are sufficient staffing was eccessary care and services of owing care areas: The facility assess, treat and monitor a using harm when she icrobial infection in her toe ation. This deficient practice onstituting immediate jeopardy a facility failed to adequately and notify a resident's treating a rabdominal wound began to mptoms of infection and resulted in harm to the ty did not ensure residents showers in a timely manner and dequate supervision and o prevent accidents. This apple residents (#1), 2 random on and random residents who ouncil meetings in May and	F	353	In an effort to maintain desire ratios the facility has implem following measures: Sign on bonus Extra shift bonus Referral bonus Referral pot luck bonus Staff retention programs/ Ongoing advertisements surrounding newspapers On line advertisement wi moving cost assistance Corporate float pool supp Paying for and transpor persons to sister facility to classes Agency staff when neces The facility continues to staff greater than the mandated 2. MONITORS ED and DON will monitor the review of the daily staffing	activities in the port ting for C.N.A. sary f at a 4 ppd.	
	causing harm whe	y sustained by resident #1 en she developed a ction in her toe requiring					

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Event ID: IKDX11

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S. Bde 20

PRINTED: 07/06/2006 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		135127	B. WING _		ne	C	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT			11	EET ADDRESS, CITY, STATE, ZIP CODE 25 N DIVISION ST ANDPOINT, ID 83864	06/22/2006 DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD RE	(X5) COMPLETION DATE	
	and intravenous and serious harm to the immediate jeopardy caregiver visiting the wound on the reside toe which required I antibiotic treatment. Resident #1 was had to adequately assest treating physician in resident's abdominated signs and symptoms deterioration. Refer to F309 for span b. The facility did no baths or showers in the shad been bather to be tween 5/2/06 and transported to the empolymicrobial toe inference of May and June 20 residents complained in the shad been between 5/2/06 and transported to the empolymicrobial toe inference of May and June 20 residents complained in the shad been between 5/2/06 and transported to the empolymicrobial toe inference of May and June 20 residents complained in the shad been between 5/2/06 at 10:55 am. acknowledged that resident residents are considered to the residents complained in the shadow of the shadow o	treatment with oral, topical, tibiotics. This resulted in resident, constituting of the constituting of the resident, discovered a sent's right great toe and 2nd nospitalization and aggressive of the constitution and aggressive of the	F 353				
RM CMS-2567	(02-99) Previous Versions O	bsolete Event ID: IKDX11	Facility ID:	MDS001420 If contin			

J. Zder ED 07-17-06

Facility ID: MDS001420

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	LE CONSTRUCTION (X3) DATE SU COMPLE				
		135127	R WING) Nanne		
NAME OF P	ROVIDER OR SUPPLIER	133127	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 06/22	2/2006		
LIFE CAI	RE CENTER OF SAN	DPOINT	1	1125 N DIVISION ST SANDPOINT, ID 83864				
(X4) ID PREFIX TAG	(ÉACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 353	Continued From pa	age 49	F 353					
		I to provide adequate						
	supervision to prev Refer to F324 for f			F-490 SPECIFIC RESIDENTS		`		
F 490 SS=G	enables it to use its efficiently to attain	administered in a manner that s resources effectively and or maintain the highest al, mental, and psychosocial	F 490	measures identified under F-F-225, F-309, F-312, F-314, and F-353 OTHER RESIDENTS This practice has the potential	166, F-324 Il to affect			
	by: Based on staff intercomplaint from the facility was not adrenabled it to use it efficiently toward to the facility failed to monitor a resident she developed a prequiring hospitalize resulted in harm, of to the resident. The assess, monitor, a physician when he show signs and sy deterioration. This resident. The facility received baths or signs and sy deterioration.	erview, record review, and a public, it was determined the ministered in a manner that is resources effectively and the betterment of each resident. To adequately assess, treat and its injury causing harm when colymicrobial infection in her toe exaction. This deficient practice constituting immediate jeopardy in a facility failed to adequately and notify a resident's treating in abdominal wound began to emptoms of infection and resulted in harm to the ity did not ensure residents showers in a timely manner and dequate supervision and		all residents. Please refer to of measures identified under F-F-225, F-309, F-312, F-314, and F-353 SYSTEMIC CHANGES Please refer to the systemic of identified under F-166, F-22, F-312, F-314, F-324 and F-3 MONITORS Please refer to the monitors if under F-166, F-225, F-309, IF-314, F-324 and F-353 DATE OF COMPLIANCE:	166, F-324 changes 5, F-309, 53 identified F-312,			

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SANDPOINT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1125 N DIVISION ST SANDPOINT, ID 83864 ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
LIFE CARE CENTER OF SANDPOINT CAPID CAPID SUMMARY STATEMENT OF DEFICIENCIES SANDPOINT, ID 83884			135127	1	***************************************	-	•	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 490 Continued From page 50 assistive devices to prevent accidents. This affected 1 of 1 sample residents (#1), 2 random residents (#8 & 15), and random residents who attend Resident Council meetings in May and June 2006. Findings include: 1. The facility failed to adequately assess, treat and monitor a resident's injury causing harm when she developed a polymicrobial infection in her toe requiring hospitalization and treatment with oral, topical, and intravenous antibiotics. This resulted in serious harm to the resident, constituting immediate jeopardy. The same resident was admitted with a surgical wound to her abdomen. The resident was harmed when the facility failed to adequately assess, monitor, and notify the treating physician in a timely manner when the resident's abdominal wound first presented with signs and symptoms of wound infection and deterioration. Refer to F 309 for detailed information regarding the immediate jeopardy and harm sustained by the resident. 2. The facility did not ensure that unwitnessed falls and/or injuries of unknown origin were thoroughly investigated to rule out abuse or neglect. Also, incident and accident reports for specific residents recorded no Executive Director or designee signatures to verify the reports were reviewed to determine if the investigations were completed. Refer to F 225 for specific details. 3. The facility did not ensure residents. Refer the province of the provent accidents. Refer to the prevent accidents. Refer to the province of the prevent accidents. Refer to the province of the prevent accidents. Refer to the prevent accidents.		RE CENTER OF SAN		s.	1125 N DIVISION ST		22/2006	
assistive devices to prevent accidents. This affected 1 of 1 sample residents (#1), 2 random residents (#8 & 16), and random residents who attend Resident Council meetings in May and June 2006. Findings include: 1. The facility failed to adequately assess, treat and monitor a resident's injury causing harm when she developed a polymicrobial infection in her toe requiring hospitalization and treatment with oral, topical, and intravenous antibiotics. This resulted in serious harm to the resident, constituting immediate jeopardy. The same resident was admitted with a surgical wound to her abdomen. The resident was harmed when the facility failed to adequately assess, monitor, and notify the treating physician in a timely manner when the resident's abdominal wound first presented with signs and symptoms of wound infection and deterioration. Refer to F 309 for detailed information regarding the immediate jeopardy and harm sustained by the resident. 2. The facility did not ensure that unwitnessed falls and/or injuries of unknown origin were thoroughly investigated to rule out abuse or neglect. Also, incident and accident reports for specific residents recorded no Executive Director or designee signatures to verify the reports were reviewed to determine if the investigations were completed. Refer to F 225 for specific details. 3. The facility did not ensure residents received adequate supervision to prevent accidents. Refer	PREFIX	(EACH DEFICIENC)	MUST BE PRECEEDED BY FULL	PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
4. The facility did not ensure residents received baths or showers in a timely manner. Refer to F M CMS-2567(02-99) Previous Versions Obsolete Event ID: IKDX11 Earlity ID: MDS001409	to the second se	assistive devices to affected 1 of 1 sam residents (#8 & 16) attend Resident Co June 2006. Finding 1. The facility failed and monitor a reside when she develope her toe requiring howith oral, topical, arresulted in serious constituting immediatesident was admitted the resident was admitted to adequate with signification and deterior detailed information jeopardy and harm so thoroughly investigated and/or injuries of the facility did not falls and/or injuries of the facility did not falls and/or injuries of the facility did not falls and/or injuries of the facility did not be specific residents report designee signature or designee signature or designee signature of the facility did not adequate supervision of 324 for specific the facility did not be at the facility did not saths or showers in a second control of th	o prevent accidents. This aple residents (#1), 2 random and random residents who buncil meetings in May and is include: If to adequately assess, treat lent's injury causing harm and a polymicrobial infection in aspitalization and treatment and intravenous antibiotics. This harm to the resident, ate jeopardy. The same led with a surgical wound to resident was harmed when the quately assess, monitor, and mysician in a timely manner abdominal wound first is and symptoms of wound bration. Refer to F 309 for regarding the immediate sustained by the resident. It ensure that unwitnessed of unknown origin were ted to rule out abuse or not and accident reports for corded no Executive Director res to verify the reports were not if the investigations were F 225 for specific details. It ensure residents received in to prevent accidents. Refer details.	F 490				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		135127	B. WII				С
NAME OF F	PROVIDER OR SUPPLIER	100121	<u> </u>	675		06/2	22/2006
LIFE CARE CENTER OF SANDPOINT				11	REET ADDRESS, CITY, STATE, ZIP CODE 125 N DIVISION ST ANDPOINT, ID 83864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 490	Continued From pa	ge 51	F	190			
	312 for specific deta	ails.					
	5. The facility did no ulcer from developing details.	ot prevent a Stage 2 pressure ng. Refer to F 314 for specific		***************************************			
	6. The facility failed in a timely manner. details.	to resolve resident grievances Refer to F 166 for specific		***************************************			
	was provided to me- services of residents resident who was no monitored, and treat abdominal wound. E	et ensure sufficient staffing et necessary care and s. This resulted in harm to a ot adequately assessed, ted for a toe injury and an Both wounds resulted in ntibiotic treatment. Refer to F iils.		***************************************			
				THE REAL PROPERTY OF THE PROPE			
ODM CMC occ	27/02 00\ 22			L_			

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Event ID: IKDX11

Facility ID: MDS001420

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S. Bolan

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Bureau of Facility Standards (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 06/22/2006 135127 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1125 N DIVISION ST LIFE CARE CENTER OF SANDPOINT SANDPOINT, ID 83864 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 000 C 000 INITIAL COMMENTS STATE The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during a complaint investigation at your facility. The surveyors conducting the investigation survey were: Marcia Key, RN, Team Coordinator Lisa Kaiser, RN C 175 Please refer to POC for F-225 C 175 C 175 02.100,12,f f. Immediate investigation of the RECEIVED cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. FACILITY STANDARDS This Rule is not met as evidenced by: Refer to F 225 as it relates to the facility's failure to thoroughly investigate incidents and accidents to rule out abuse or neglect. C 784 Please refer to POC for F-309 C 784 C 784 02.200,03,b b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Based on staff interviews, record review, and a complaint from the public it was determined the facility failed to adequately assess, treat and Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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(X6) DATE

S. Bolen

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57-17-06

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TITLE

Bureau of Facility Standards (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 06/22/2006 135127 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1125 N DIVISION ST LIFE CARE CENTER OF SANDPOINT SANDPOINT, ID 83864 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 784 Continued From page 1 C 784 monitor a resident's injury causing harm when she developed a polymicrobial infection in the toe requiring hospitalization and treatment with oral. topical, and intravenous antibiotics. This deficient practice resulted in serious harm, constituting immediate jeopardy to 1 of 1 sample residents (#1). a. Resident #1 scraped her right great toe on 3/29/06 while in the facility, causing the toe to bleed at the toenail. The facility could not provide any documentation indicating the toe was assessed after the initial incident nor that it was treated or monitored. On 5/23/06, a private caregiver removed the resident's socks and observed a wound to the right great toe. The wound was visualized after the resident's toenail was pulled off due to the removal of the sock. Documentation on the incident report, dated 5/23/06, described the wound as a "...large open area..." with "yellow slough covering wound [and] necrotic tissue @ [at] tip of toe." The incident report also documented a 0.5 centimeter lesion to the medial second toe with a yellow wound base. The resident was sent to a local emergency room and admitted to the hospital for evaluation and treatment. It was determined she required intravenous antibiotics for a diagnosed infection. This failed practice was brought to the attention of the facility's Administrator, DON, Corporate Nurse Consultant and the Director of Medicare Services on 6/21/06 at 6:15 pm. The facility was provided with specific details of this deficient practice that resulted in a serious wound to resident #1. On 6/22/06 at 12:40 pm the facility presented the surveyors with an acceptable plan of correction and the immediate jeopardy was abated.

Bureau of Facility Standards STATE FORM

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IKDX11

Bureau of Facility Standards (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 06/22/2006 135127 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1125 N DIVISION ST LIFE CARE CENTER OF SANDPOINT SANDPOINT, ID 83864 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 784 Continued From page 2 C 784 The plan of correction was as follows: "1. Resident #1's wound has been assessed and documented. Braden Skin Risk Assessment has been updated. Care Plan has been reviewed and updated to reflect residents current medical status. 2. All residents feet were assessed for skin breakdown on 5/23/06 and 5/24/06. No new skin breakdown was identified. Head to toe skin checks completed on residents on 6/21/06 and 6/22/06 and documented on weekly skin check sheets. 3. L.N.'s will be inserviced on LCCA's [Life Care Corporation of America's] Prevention of Pressure Sores and Other Ulcers Policy by 6/23/06. CNA's will be inserviced on procedure for reporting skin issues on 6/23/06. Braden Risk Assessments will be updated for all residents. Residents scoring 14 or below will have Pressure Ulcer Prevention Checklist completed. Residents identified at moderate or high risk for skin breakdown, will have Care Plan's reviewed and updated. To be completed by 6/30/06. LN's will be inserviced on LCCA skin documentation forms for Pressure Ulcers, Stasis Ulcers, and non-pressure related skin on 6/23/06. All skin issues identified will be recorded on approp. [appropriate] skin form, assessed weekly with documentation until resolved per LCCA policy by 6/23/06 and ongoing.

Bureau of Facility Standards STATE FORM

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Bureau of Facility Standards (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 06/22/2006 135127 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1125 N DIVISION ST LIFE CARE CENTER OF SANDPOINT SANDPOINT, ID 83864 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 784 Continued From page 3 C 784 Weekly head to toe skin integrity assessments will be performed and documented on each resident's individual Weekly Skin Integrity Assessment form by 6/22/06 and ongoing. Residents identified with Dx. [diagnosis] of Diabetes will have weekly Diabetic Foot Checks completed by L.N. and documented on individual treatment sheets. Care Plans will be updated to reflect new intervention by 7/1/06 and on-going. L.N. inservice on 6/23/06 to include policy & procedure for initiation and completion of Weekly Diabetic Foot Checks. Ongoing LN inservices will be provided on Wound Assessment and Documentation. Complications of Diabetes and Prevention of Pressure Sores and Other Ulcers on New Hire Orientation, and quartly [sic] for all LN staff. SDC [Staff Development Coordinator] will complete L.N. Competencies on Pressure Ulcer Assessment and Pressure Sore Management Treatment Modalities for each L.N. By 7/30/06. Newly hired L.N.'s will complete competencies during probationary period. 4. RCM [Resident Care Manager] will audit treatment sheets for completion of Weekly Diabetic Foot Checks, Weekly Skin Integrity Assessment forms, individual skin assessment sheets for completion daily, with copy of audit to D.O.N. by 7/1/06 and ongoing. D.O.N. to do random audit of Weekly Skin Integrity Assessment forms, Individual Skin assessment sheets, and treatment sheets for Diabetic Foot Checks by 7/1/06 and ongoing.

Bureau of Facility Standards STATE FORM

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Bureau of Facility Standards (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 06/22/2006 135127 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1125 N DIVISION ST LIFE CARE CENTER OF SANDPOINT SANDPOINT, ID 83864 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 784 C 784 | Continued From page 4 RCM will complete LCCA Weekly Pressure Ulcer Tracking form and the Weekly Non-Pressure Tracking form and forward copy to D.O.N. by 7/1/06 and ongoing. D.O.N. will do random chart audits for residents identified with newly acquired Pressure Ulcers to ensure approp. notification, treatment plan and documentation is in compliance. D.O.N. will do random chart audit for new admissions to ensure assessments, documentation and treatments are approp. Audits completed and reviewed by D.O.N. will be evaluated monthly for performance improvement opportunities by the CQI [Continuous Quality Improvement] committee. The E.D. [Executive Director] will monitor and ensure compliance." "Amendment to P.O.C. [plan of correction] 6/22/06 The Nurse Consultant that will be in the facility/available for consultation effective 6/22/06 is [name and credentials of RN #1] (licensed in ID [Idaho]). [Name of RN #1] will be in the facility until Name of Corporate Nurse Consultant and credentials (RN#2)] has received her ID license. [Name of Corporate Nurse Consultant] has started this process today. The Nurse Consultant will monitor and insure compliance of P.O.C. [Name of RN #1] will remain in this capacity for a minimum of 3 wks [weeks]. At that point if [name of RN #2] has her ID license then she will become the consultant if not [RN #1] will remain until [RN #2] receives her license."

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her abdomen.

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had a dressing over the right lower quadrant of

admission assessment, the form documented an

A "Weekly Skin Integrity Assessment" form documented an assessment, dated 3/27/06. In

addition to the wounds identified on the

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FORM

a local emergency room for evaluation.

The investigation portion of the report

it as an "infected lesion." The "How did it happen?" section of the investigation form documented, "Res has hx [history] of stubbing

was applied, and the resident was transported to

documented a skin related injury and categorized

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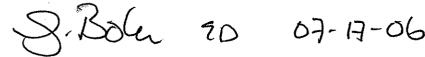
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Bureau of Facility Standards (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION · STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 06/22/2006 135127 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1125 N DIVISION ST LIFE CARE CENTER OF SANDPOINT SANDPOINT, ID 83864 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 784 C 784 Continued From page 8 LN], LPN what had just happened and also got Social Services Assistant [name] involved. [Social Services Assistant] then notified [a second LN's namel. LPN of the incident who went to the Residents room, looked at the toe, covered it with a dressing and notified the Physician. She also notified [name of corporate nurse consultant] of the incident. An incident report was initiated. On 5/23/06 & 5/24/06 All Residents in the facility had their feet checked for any unidentified skin issues. There was no new skin breakdown noted. MDs were notified if Podiatrist evaluations were needed. Residents that had not had a shower in the past week were identified and received a shower. On 5/23/06, Facility investigation to rule out abuse or neglect was initiated Executive Director [name] contacted [physician's name] to find out the status of [resident #1's] great toe, he [the physician] felt at that time the infection was part of a possible Hematogenous infection that spread from her open abd [abdominal] wound, and he did not feel that this was from abuse or neglect. On 5/24/06 [name of Executive Director] interviewed staff members who provided care to [resident #1], all staff members that were interviewed stated that they did not remember any open wounds on her right great toe & most could not remember seeing her without her socks on [,] list of staff that were interviewed [list of 10 namesl... After chart review and staff interviews abuse and neglect could not be substantiated. Facility Management discussed plan to identify training needs of staff members and develop a

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Bureau of Facility Standards (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED. AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING _ 06/22/2006 135127 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1125 N DIVISION ST LIFE CARE CENTER OF SANDPOINT SANDPOINT, ID 83864 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID. (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 784 Continued From page 9 C 784 training plan/ schedule when new DON started her position on 5/31/06. On 6/21/06 Interviewed [name of occupational therapist] who was the OT [occupational therapist] providing showers and ADL training until the end of March, during that time she was showered 3 times per week by OT. She was not making any progress so OT did not continue to work with her. [resident #1] did stub her right great toe during that time and the toe was bruised and oozing, [name of OT] did notify [name of LN] at that time and that [name of same LN] was applying a dressing." The resident's bath records were reviewed for the month of May 2006. The only documented shower was on 5/2/06. There was no other documentation in the resident's record to indicate she had been bathed or showered any time between 5/2/06 and 5/23/06 when she was transported to the emergency room for the polymicrobial toe infection. The bath record for the month of April revealed the occupational therapist showered the resident on 4/7, 4/10, 4/11/, 4/12, 4/17, 4/19, 4/21, 4/24, and 4/28/06. Weekly skin assessments were documented as completed for the resident on 3/27, 4/1, 4/8, 4/15, 4/29, and 5/7/06. There was no other documentation to indicate if skin assessments had been performed after 5/7/06. The weekly skin assessments contained no documentation pertaining to the resident's feet or toes. An interview was conducted with the DON and the RN Director of Medicare Services on 6/21/06

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at 4:06 pm. When asked to provide assessments

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4/14/06 4:00 am - "Dressing [change] completed [with] wound on RLQ. Purulent, foul smelling pus cleaned from bottom of wound..."

*4/12/06 2:10 pm - "...Wound open & draining copious amounts of yellow & purulent drainage. Very foul odor coming from wound. Wound bed has exposed adipose tissue, lower aspect of

*4/12/06 9:00 pm - "Wound was full of purulent

*4/13/06 10:10 pm - "...Dressing changed this evening [right] abdomen - purulent drainage lying in wound - soaked up by 4 x 4's and cleansed w/normal saline. Wet to dry dressing covered

wound is black & dry..."

w/ABD. [Increased] odor."

pus...."

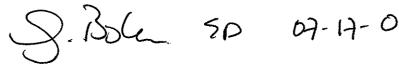
4/14/06 4:00 pm - "Late entry for 4/13/06...Abd wound con't to have copious amounts of purulent drainage & very foul odor. Outer, most inferior aspect black & necrotic..."

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/SU			(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		135127		B. WING			06/22	; 2/2006 :
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LIFE CAP	RE CENTER OF SANI	DPOINT	1125 N DIV SANDPOIN	/ISION ST NT, ID 8386	4			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETE DATE	
C 784	Continued From pa	ige 16		C 784			:	
	wound infection and document a "fishy" 4/6/06 and continue of a foul odor with a The resident's phys 4/10/06 and a wour until 4/11/06. Antibi until 4/16/06, a full began to show evic deterioration. This charm to the resider infected with Protect Pneumonia, and El antibiotic treatment When the resident on 5/23/06, hospita "chronic non-healing time of the complaint in the resident on the terms of the complaint in the resident on the terms of the complaint in the resident of the resi	signs and symptoms of deterioration. Nursi smell from the wouned to document the pubsequent dressing sician was not notified and culture was not or totic treatment did no 10 days after the wordence of infection and delay in treatment result; her abdominal words Mirabilis, Klebsiell interococcus Faecalist and eventually a wowas admitted to the dization identified she ag abdominal wound. Int investigation on 6 ded the use of a wounded to document the properties and the use of a wounded to document the properties and the use of a wounded to document the properties and the use of a wounded to document the use of a wounded to the use of a wounded to document the use of a wounded to the use	ing notes d on vesence changes. d until dered t begin und disulted in und was a required und vac. hospital e had a "At the /21/06, the					
C 785	02.200,03,b,i			C 785	C 785	Please refer to POC	for F-312	
	body, skin, nails, he and face, including shaving of hair in a patient/resident wis necessitated to pre This Rule is not m Please refer to F 3	the removal or ccordance with shes or as event infection; et as evidenced by: 12 as it addresses throoming and cleanlin				i i		
C 789	02.200,03,b,v			C 789	C 789	Please refer to POC f	or F-314	
	v. Prevention of condeformities or treating if needed, including acility Standards			and an artist of the state of t				

STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		135127				06/22/2006	
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
LIFE CAI	RE CENTER OF SANI	OPOINT	1125 N DIV SANDPOIN	/ISION ST NT, ID 8386	4		
(X4) ID PREFIX TAG	EX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
C 789	Continued From pa	ge 17		C 789	,		
	to, changing position hours when confine wheelchair and oppexercise to promote This Rule is not make Refer to F 314 as it to prevent a Stage developing.	ed to bed or portunity for e circulation;	's failure n				
C 790	02.200,03,b,vi		!	C 790	C 790 Please refer to POC for	or F-324	
	vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F 324 as it relates to the facility's failure to provide adequate supervision to prevent accidents.						
	roility Standards		<u>J</u>				

Bureau of Facility Standards

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3. 2 sh 50 07-17-06

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